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ABSTRACT

This volume of 12 lessons--each one written by either a medical or a mental health professional--provides expert information on a variety of medical and psychological issues in rehabilitative counseling. The lessons, each of which concludes with a few multiple-choice questions, are as follows: (1) "Rehabilitation of the Seriously Mentally Ill" (Robert Paul Liberman and Jeremy Engel); (2) "Post-Stroke Depression" (Rajesh M. Parikh and Robert G. Robinson); (3) "Stress 'Addiction': Causes, Consequences, and Cures" (Paul J. Rosch); (4) "Visual-Perceptual Rehabilitation in Psychiatric Patients" (Frederic Flach and Melvin Kaplan); (5) "Cognitive Therapy for Depression" (Robin B. Jarrett and A. John Rush); (6) "Listening Processes in Psychotherapy and Counseling" (Fraser N. Watts); (7) "Diagnosis and Management of Substance Abuse" (Edward C. Senay); (8) "Current Developments in Group Psychotherapy" (Henry I. Spitz); (9) "Obsessive-Compulsive Disorder: New Findings" (Thomas R. Insel); (10) "The Criminal Personality" (Stanton E. Samenow); (11) "Creativity and Mental Illness" (Anthony Storr); and (12) "Diagnosis and Treatment of Passive-Aggressive Personality Disorder" (Allen Frances and James Widiger). (Contains an index. Each lesson contains references.) (RJM)

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Directions in
Rehabilitation
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VOLUME 1 • LESSON 1

Rehabilitation of the Seriously Mentally Ill

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Directions in Rehabilitation Counseling

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EDITOR'S NOTE

Recent studies indicate that approximately 75% of deinstitutionalized, chronically mentally ill patients are unable to remain in the community for more than three years. Another telling study reports that the outcome for these individuals does not depend upon psychopathological symptoms or diagnostic categories, but rather upon having the necessary skills for effective living, e.g. social, family, and vocational skills.

New behavioral modalities offer promise in equipping seriously mentally ill individuals with skills for reintegration within society. These modalities will have particular relevance for the rehabilitation counselor and psychologist, as well as the recreational and occupational therapists who involve patients in learning how to relate with others, engage in competition, think creatively, and establish positive self-images.

In this lesson, the authors present a comprehensive psychiatric rehabilitation approach for treating seriously mentally ill persons. The discussion includes: social-skills training, behavioral family management, and the job-finding club. Using behavioral learning techniques, social-skills training targets those skills needed in interpersonal situations. Models addressing specific learning disabilities, cognitive problem-solving, and attention-focusing deficits which are associated with many chronic psychiatric disorders are also presented. Behavioral family management, in turn, provides behavioral analysis and stress management, as well as serving an educational and problem-solving function for family members. Learning skills for conducting an effective job search are emphasized in the job-finding club.

While this lesson focuses upon the seriously mentally ill, the rehabilitation practitioner may adapt these modalities for use with diverse patient populations in a variety of settings. The rehabilitation principles and concepts are applicable for all individuals needing to sharpen social skills, cultivate friendships, improve family communications, and make wise vocational decisions.

Introduction

Following the initiation of deinstitutionalization two decades ago, treatment of chronic and seriously mentally ill patients consisted primarily of brief hospitalization, crisis intervention, and medication to relieve acute symptoms, followed by inconsistent and inadequate psychosocial support services. The same two decades have been the emergence of the revolving door syndrome--that **pattern of admission, discharge, and readmission to psychiatric facilities that is so demoralizing for patients, their families, and the health professionals who serve them.** For example, studies indicate approximately 75% of chronic mentally ill patients fail to remain in the community for more than three years.[1]

Recently, treatment development, research, and clinical applications have yielded new modalities that offer substantial benefits to the long-underserved, seriously mentally ill. Those innovations in treatment and rehabilitation arise from procedures that protect against and filter the noxious effects of biological vulnerability and socio-environmental stress. In combination with judicious doses of antipsychotic medication, **coping and competence, generated by behavioral therapies, can minimize long-term symptom impairments, social and occupational disabilities, and handicaps associated with serious mental disorders such as schizophrenia.**

Thus, appropriate dosing of neuroleptic drugs can delay and abort relapses; **social skills can be strengthened through training** and protect a vulnerable individual from succumbing to stressful life events. Family intervention and participation in a psychosocial self-help club can bolster social support and buffer the noxious effects of tension and stressors from the environment.

What is Psychiatric Rehabilitation?

Comprehensive psychiatric rehabilitation encompasses assessment, training in personal skills, and modification of living environments in those areas relevant to community life. They cover self-care, including medication and symptom self-management; family relations; peer and friendship relations; avocational and employment pursuits; money management and consumerism; residential living; recreational activities; transportation; food preparation; and choice and use of public agencies.[2] Because comprehensive rehabilitation involves so many areas of the patient's life, the responsible rehabilitation practitioner, primary therapist, or case manager must galvanize the active involvement of the patient and his or her own family as well as the full spectrum of community support services. Thus, **rehabilitation encompasses two major strategies:**

- Helping the patient develop or re-acquire social and instrumental skills
- Modifying the patient's social environment to become more supportive, enabling compensation for continuing impairments, disabilities, and handicaps.

Social-Skills Training for Chronic Mental Patients

Social-skills training has proved to be effective in increasing the social competence of chronic mental patients. Social-skills training is designed to teach specific interpersonal skills and to promote the generalization and maintenance of those skills.[3] Skills training procedures, which are based on principles of human learning, have been empirically tested and packaged for ready use by practitioners.

While many psychosocial programs include self-styled social-skills training, it is important to distinguish between nonspecific group activities that engage patients in socialization and methods that deliberately and systematically use behavioral learning techniques in a structured approach to skill-building. Although socialization activities can lead to acquisition of skills through incidental learning during spontaneous social interactions,[4] we shall limit our definition of social-skills training to methods that incorporate principles of human learning designed to promote the acquisition, generalization, and durability of skills needed in interpersonal situations.[5]

The learning disabilities of many chronic psychiatric patients require the use of highly directive behavioral techniques for training social skills. For example, most chronic patients have attentional and information-processing deficits. They show hyperarousal or underarousal in psychophysiologic testing, and they experience overstimulation from emotional stressors or even from therapy sessions that are not carefully structured and modulated. Chronic patients often fail to be motivated by the customary forms of rewards available in traditional therapy. In addition, they generally lack conversation skills, a basic building block for social competence. Schizophrenic patients, in particular, are deficient in social perception and have difficulty finding alternative ways of coping with everyday problems, such as missing a bus, making an appointment, or getting help with bothersome drug side effects. Schizophrenic patients tend to make less eye contact, are less fluent verbally, and use less vocal intonation, all of which may impair social learning.

It is important to design social-skills training procedures to fit the needs of the individual patient, since all patients present different constellations of social abilities and deficiencies. Several training models are currently available to the clinician. Longest in use is a basic treatment package that calls for the tailoring of individual goals, demonstration of appropriate skills to the patient, the role-playing of interpersonal situations, and the provision of reinforcement and corrective feedback.

The Basic Model of Social-Skills Training

In the basic model, social-skills training is generally conducted in a clinic or hospital training room with either an individual patient or a group of patients. To increase the generalization of treatment effects, additional training takes place in settings such as the patient's home, hospital ward, or community facility. The therapeutic process is designed to gradually shape the patient's behavior by reinforcing successive approximations of the appropriate skill.

Researchers and clinicians have succeeded in training patients in a full range of verbal and nonverbal social skills. They include assertive responses,[6,7] nonverbal behaviors like eye contact and smiles,[8,9] paralinguistic behaviors like voice volume or speech duration,[10,11] conversational skills such as asking questions and giving compliments,[12,13] community-based interactions with agencies or shops,[14] and job interview skills.[15,16]

The Problem-Solving Model for Training Social Skills

Deficits in cognitive problem-solving abilities, which may lead to ineffective performances in social situations, have been found in many chronic psychiatric patients.[17,18] The problem-solving method of teaching social skills views interpersonal communication as a three-stage process requiring:

1. Receiving skills--accurately perceiving cues and contextual elements of interpersonal situations
2. Processing skills--generating response options, assessing the consequences of each alternative, and selecting the most feasible option
3. Sending skills--integrating both verbal and nonverbal skills in implementing the chosen option for an appropriate social response.

In the problem-solving training model, an interpersonal scene is role-played and videotaped. After role-play, the therapist asks questions to assess the patient's receiving skills. The next step in the training process is the assessment and training of processing skills. During that stage the patient is taught to generate response options and to identify the consequences, both positive and negative, of those options. Role-play conversations are conducted. Specific questions are asked to gauge the patient's ability to process information, and the therapist prompts alternative responses that are appropriate for the patient's skill level.

The third stage of training involves sending skills. During role-play interactions, patients are coached to improve their performance and are asked to assess and reinforce their accomplishments. (In all three stages of this model, the therapist may prompt or model correct responses or ask that the scene be role-played again.) When sending skills are performed at an acceptable level, assessment and training continue with a new interpersonal situation.

The scope of the problem-solving model has been expanded to include areas of social and independent living other than conversational skills.[19] **Training "modules" have been developed in the areas of leisure and recreation, medication management, symptom self-management, and grooming skills, among others.** The modules are designed to teach specific functional skills, to train the patient to solve problems which may be encountered while attempting to employ those new skills, and to practice the skills *in vivo*.

The structure of a module, which focuses on the domain of medication self-management, is depicted in Figure 1. It contains skill areas in (a) obtaining information and learning about the benefits of maintenance antipsychotic medication, (b) acquiring the skills of self-administration and self-assessment of medication, (c) identifying and coping with the side effects of medication, and (d) negotiating medication issues with physicians and health-care providers. Patients can enroll in one or more modules, depending on the extensiveness of their deficits and the nature of the goals established for their treatment.

This model of social-skills training offers considerable promise for those who have the cognitive capacity for learning social skills in small groups that meet for one hour at a time. Each module is divided into separate skill areas, and each area has specific behaviors taught to achieve personal effectiveness and competence. **Patients proceed through each skill area in sequence, starting with an introduction that**

highlights the values and advantages of the skills which, in turn, motivates subsequent participation. After acquiring the skills in the training phase, patients learn how to gather the tangible and social resources required to put the skills to use. **For example, in order to negotiate medication side-effects or dosage issues with the prescribing physician, a patient must be able to use a telephone to make an appointment with the doctor and to find transportation to the doctor's office.** After solving resource management problems, patients anticipate obstacles and problems that might interfere with the successful implementation of their skills in the natural environment. **Thus, patients learn how to deal with disappointing events such as the lateness or unexpected absence of the physician.** The learning activities in the modular approach to training problem-solving skills are shown in Figure 2.

FIGURE 1

Each module is divided into separate skill areas, with each area having specific behaviors, or educational objectives, that are taught for personal effectiveness. In this example of the Medication Management Module, patients learn a variety of verbal and nonverbal skills in negotiating their medication issues with their health care provider.

Module: Medication self-management

  Skill area: Negotiating medication issues

    Requisite behaviors:

- Pleasant greeting
- Describe problem specifically
- Tell length of occurrence
- Describe extent of discomfort
- Specifically request action
- Repeat/clarify advice/orders
- Ask about expected time for effect
- Thank for assistance
- Good eye contact
- Good posture
- Clear audible speech

FIGURE 2

Learning activities in each skill area of modules designed to teach chronic mental patients a range of social and independent living skills.

Learning Activities In Each Skill Area	
1. Introduction to skill area	Introducing the topic and component skills with a rationale; and motivating the patients to participate.
2. Videotape and questions/answers	Viewing the skills being modeled in the videotape scene, which demonstrates skill usage with question/answer review
3. Role play	Practicing the skills
4. Resource management	Discussing the resources needed to perform the skills
5. Outcome problems	Solving problems associated with using the skill
6. In vivo exercises	Performing exercises in real-life situations with healthcare providers, in settings outside the training class
7. Homework assignments	Completing assignments autonomously

The Attention-Focusing Model for Training Social Skills

The problem-solving training model, as well as the basic approach, relies on the patients' ability to attend to relatively complex training situations that last 30 to 90 minutes. A sizable number of chronic psychiatric patients have such severe impairments in the cognitive and attentional realms, however, that they are unable to benefit from those training models. A method that minimizes demands on cognitive abilities when such patients are undergoing social-skills training has been recently developed.[3] The attention-focusing procedure is characterized by multiple, controlled training trials, the sequential presentation of training material, and graduated and systematic prompting following incorrect responses. That procedure has been used to teach conversational skills to highly distractable, institutionalized, chronic schizophrenics.[20]

A trainer initiates a training trial with a patient by making a

statement. If the patient responds appropriately, he or she is praised and the response is sometimes reinforced with something to eat or drink. If an incorrect response is made, the trainer implements a sequence of prompts. The patient is praised if he or she responds appropriately following the prompts. The same statement is presented by the trainer until the patient responds correctly several times in succession without prompting. The technique is then repeated using other conversational statements.

The first goal of training is to teach the patient to ask relevant questions. For example, if someone were to make a statement such as, "I went to a movie last night," the patient is trained to make a response such as, "What movie did you see?" If patients are unable to deliver an acceptable response on a trial, the trainer models a response; however, any appropriate response made by the patient is accepted as correct. Typically, patients are trained on 8 to 12 alternative exemplars in each of three domains of conversational skills.

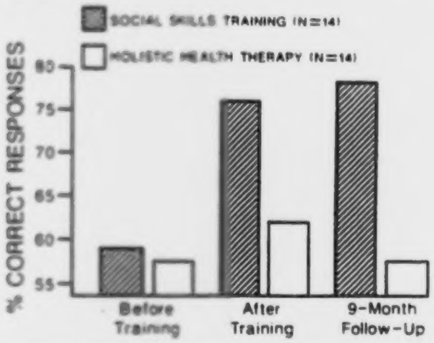
Effectiveness of Social-Skills Training

Given the considerable effort necessary to implement a social-skills training program, it is reasonable to question its effectiveness, durability, and generalizability. **Well-controlled studies have shown that patients with chronic schizophrenia can learn a variety of functional social skills and maintain those skills over time.**[21] When skills training is intensive and extensive, skills do not weaken substantially with the passage of time; however, booster sessions are desirable, as any knowledge or skill can erode when infrequently used or reinforced.

In a study conducted at Camarillo State Hospital, **patients were** randomly assigned to receive either social-skills training or a holistic therapy program that included art therapy, jogging, and meditation.[22] The holistic therapy was credible to the patients and actually resulted in significant symptom improvement during the inpatient period. Patients' skill levels were measured through a role-playing test that was conducted before therapy, immediately at the end of the three-month program, and at a nine-month follow-up. As shown in Figure 3, patients who received social-skills training showed a large increase in appropriate skills displayed during the role-playing test, even though the tests were conducted using situations novel to the patient. Furthermore, this increase was as apparent at the nine-month follow-up as it had been immediately after training. Patients who received the holistic therapy demonstrated little change in social skills at either the three-month or the nine-month test.

FIGURE 3

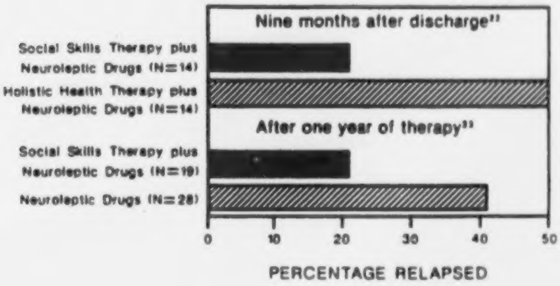
Percentage of correct responses on role-play test of social skills.



To enable patients to generalize their newly learned skills and apply them to novel situations, it is necessary to program for gener-

alization during the training. One has to anticipate the environments that the patient will encounter after the training is over. When such anticipation and planning is built into the training program, there is good evidence that patients are able to transfer the newly learned skills to the natural environment. Patients in the study just described were asked to participate in a naturalistic conversation test outside the hospital and clinic with a person they had never met. **Patients who had received the social-skills training were significantly less hostile, less distracted, less submissive and inhibited, and more appropriate to their conversational partner than were those who had received the holistic therapy.** Relatives of the patients who had received the social-skills training also rated them (using the Katz Social Adjustment Scale) as much improved in areas related to the training.

FIGURE 4



Relapse rates in two controlled studies of maintenance antipsychotic drug therapy with or without social skills training.[22,23]

Skills training, coupled with pharmacotherapy, may actually reduce the risk of relapse of schizophrenia patients. Figure 4

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illustrates the relapse rates from two studies that compared the combination of skills training and maintenance pharmacotherapy.[22,23] In both studies, relapse after 9 to 12 months occurred in approximately 20% of patients receiving the combination of skills training plus drug treatment, but was found in more than 40% of patients not receiving the skills training.

Behavioral Family Management

Behavioral family management is a family-based, skills-training effort that also works to reduce stress and make the family a more supportive environment for the schizophrenic patient. Behavioral family management is characterized by three elements: (1) **education about the nature and management of schizophrenia,** (2) **training in verbal and nonverbal communication skills**, and (3) **training and practice in effective problem-solving skills.** Although its methods are similar to those used for training in other skills, only behavioral family management requires that both patient and relatives participate in the systematic process of alleviating the considerable problems and stress associated with living with a serious mental disorder.

Based on intensive interviews with 80 relatives of schizophrenics, Creer identified three categories of problems: (1) **distress caused by the patient's symptomatic and socially impaired behavior**, (2) **anxiety and "burnout" experienced by the relatives,** and (3) **disturbances in the relatives' own social networks.**[24]

From the families' perspective, schizophrenic members living at home display two major types of behavior that are distressing: social withdrawal and solitary patterns on the one hand and aggres-

sive, bizarre, and disruptive behavior on the other. Social isolation, to the point of rarely engaging in conversation, is the more common pattern; it generates helpless frustration in relatives whose sustained social support for the patient requires a modicum of responsiveness. Also posing challenges to family coping are the apathy and indolence of the chronic schizophrenic, which galls relatives who view the patient as physically able and yet do not understand the absence of constructive activity.

Relatives speak of being "constantly on a knife edge," "living on your nerves," or "feeling in constant dread of relapse and flare-ups of symptoms." Guilt, exhaustion, depression, anxiety, and anger are frequent emotions experienced by relatives that, in combination with the patients' deviance, do much to explain the high "expressed emotion" attitudes in families--a stressful emotional climate that has been found to predict relapse.[25-27] Expressed emotion that consists of criticism, hostility, and emotional over-involvement is an understandable reaction of concerned family members who are at a loss to know how to help their schizophrenic relative. Over-involvement can lead a family to give up attachments to the outside community and to spend inordinate amounts of time at home with the patient. Criticism and hostility can lead to rejection of the patient and, ultimately, to alienation and a breach in the family relationship.

Behavioral family management comprises 16 to 20 weekly, 90-minute sessions designed for individual families or multiple-family groups and can be adapted for use with families of patients with other major mental disorders. Alternatively, it has consisted of a two-year period of more-definitive skill-building, with weekly sessions for three months and bi-weekly sessions for three months and bi-weekly sessions for six months, followed by monthly maintenance sessions. **In three empirical evaluations and controlled studies, behavioral family management has been shown to reduce family tensions, conflicts, and expressed emotion; markedly reduce relapse rates and rehospitalization; enhance problem-solving and coping; improve social adjustment of patients; and lessen the family burden.**[28,29] An analysis of cost-effectiveness indicates a home-based version of behavioral family management is more effective and less costly than comparable clinic-based treatment of individuals.

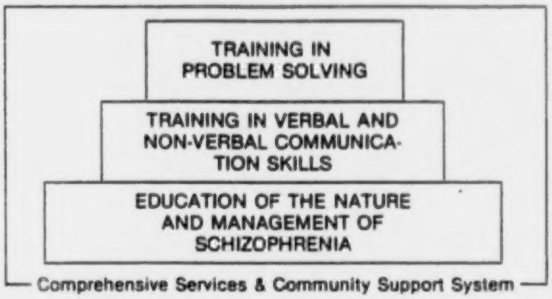
Elements of Behavioral Family Management

Behavioral family management includes in-depth behavioral analysis of each family member and of the family as a functioning, interdependent unit; education about schizophrenia and its treatment; training in communication skills; and training in a stepwise and systematic problem-solving process. As depicted in Figure 5, those program elements are imbedded in a comprehensive treatment service, including crisis intervention, medication, vocational rehabilitation, and case management.

The educational sessions are used to inform relatives and patients about schizophrenia–its causes, course, and management. Detailed information is presented, and patients and families are invited to discuss their experiences and express their feelings and concerns. The sessions function to relieve guilt, confusion, and helplessness experienced by family members as well as foster realistic expectations about treatment outcome and emphasize the importance of continued maintenance medication. The impact of schizophrenia on each family member and problems of management are discussed. Educational sessions are presented in a graphic, semi-didactic style, with visual aids, videotapes, and written materials. The patient is encouraged to take the role of "expert" and to describe his or her experiences to the family.

FIGURE 5

The elements of behavioral family management are optimized when embedded in a comprehensive array of psychiatric and social services.


TRAINING IN PROBLEM SOLVING
TRAINING IN VERBAL AND NON-VERBAL COMMUNICATION SKILLS
EDUCATION OF THE NATURE AND MANAGEMENT OF SCHIZOPHRENIA
Comprehensive Services & Community Support System

Following the information-giving sessions, the objective is to teach communication and problem-solving skills. First, the current communication pattern of the entire family is assessed to identify areas of communication skills deficits. That is followed by training and guided practice with feedback to teach four types of communication:

1. Using **active listening skills** to learn the needs and emotions of others.
2. **Expressing positive feelings and giving positive feedback**.
3. **Making requests of others, expressing expectations, and setting rules.**

4. **Expressing negative emotions directly**, such as feelings of anger and disapproval.

Research indicates families can learn problem solving. **In a study by Falloon and colleagues, families exposed to behavioral family management were significantly better able to solve their real-life problems three months after the program began than were families who received only individual therapy.** Improvements in problem-solving capacity were highly predictive of a full spectrum of positive clinical outcomes, including symptom remission, reduced likelihood of relapse, higher levels of social functioning, and reduced family burden.[30]

Job-Finding Club

The job club represents an integrated package of training, support, and management modules designed to help patients learn the skills to conduct an effective job search. Key elements of the program include the use of an environment conducive to motivating patients in their job search; the use of reinforcement strategies to make the search less demanding; an analysis of tasks involved in finding a job (to make the search more manageable); and the training skills required in a job search.

To meet the needs of the psychiatrically disabled, the structure of the job-club program is marked by daily goal-setting activities, remedial training in job-seeking skills, and staff support and counseling to help patients manage personal stressors that could affect their employment potential. Figure 6 depicts the methods used in each of the program segments.

FIGURE 6

Job Club Methods

Teaching Job-Seeking Skills

Finding job leads
Contacting employers
Using the telephone
Completing applications
Writing resumes
Interviewing for a job
Using public transportation
Grooming

Sustaining the Job Search

Daily goal setting
Frequent counselor-patient contact
Incentives
Prompting
Generous praise for effort
Peer support
Liaison with other treatment personnel

Training in Job-Seeking Skills

During the first week of the program, patients participate in an intensive, 20-hour workshop designed to assess and train basic job-finding skills. The curriculum includes identifying sources of job leads, contacting employers, completing employment applications, developing resumes, participating in job interviews, and learning how to set both long-term and daily goals, and how to use public transportation. Instruction is competency-based, with trainers using programmed materials, didactic instruction, role playing, and *in vivo* training exercises. Wherever possible, the program uses materials and situations the patient will face during the job search. For example, patients practice completing bona fide job applications and contacting actual sources for job leads. In situations where real life assessments are not possible, such as job-interview training, role playing is substituted. Patients' progress is continually monitored, and additional instruction is provided to those who fall behind or present special training needs.

Job Search

After completing the workshop, patients begin their actual job search. The program provides work areas, access to telephones, secretarial support, and job listings. Job leads are gleaned from newspaper ads, telephone directories, employment notices, civil service announcements, and weekly visits by job-placement counselors from state agencies. The patients, in turn, are expected to attend the program daily and approach the job search with the same effort and responsibility as a full-time job.

A daily, individualized goal-setting session helps patients plan and organize their job-search activities. Every morning, before beginning the day's search, each patient meets with the program staff: to identify the most advantageous options for the day's search; to develop outcome expectations for each activity and a time line for completion; and to propose solutions in advance for any stumbling blocks that may be encountered during the day. Patients are expected to keep a daily log of their job-seeking activities and account for their time. In addition to helping patients develop realistic expectations and daily goals, supportive and goal-directed counseling is also provided as needed. That encompasses not only issues directly related to the job search but other areas that could impede job-finding success, such as finding reliable housing in the community, adjusting to work hours, and learning how to interact with others.

After six years of operation at the Brentwood VA Hospital, the Job Club has served more than 500 patients. A consistent pattern has emerged. **Approximately 65% of participants not on disability pen-**

sions have secured jobs or full-time on-the-job training positions through the program. Of those, 65% have been employed at least six months.[20] Approximately 45% of persons receiving social security disability insurance find jobs, and 25% of those eligible for Social Security insurance obtain jobs.

Can Rehabilitation Promote Recovery from Psychosis?

The promising results of behavioral modalities such as social-skills training, behavioral family management, and the job-finding club raise an intriguing question: can those modalities, delivered early in the course of chronic psychoses accelerate the normalization of functioning and remissions in symptoms reported in 20- to 30-year follow-ups of schizophrenics?[31] In the study of behavioral family management described above, more than 60% of young adult chronic patients were in full remission of their psychotic symptoms at the two-year follow-up assessment. Moreover, their remissions were obtained with less antipsychotic drug overall than their counterparts who had received individual, reality-oriented, supportive therapy.

In the last decade, major inroads have been made in developing rehabilitative techniques that improve the ability of schizophrenic patients to function in society. Evidence is mounting that those techniques, combined with judicious doses of antipsychotic medication, reduce the likelihood of relapse as well. By adopting the comprehensive rehabilitation approach to the treatment of schizophrenia that combines pharmacotherapy, community support systems, and behavior therapy, we should be able to normalize more of our patients and assist them in achieving a good quality of life.

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QUESTIONS BASED ON THIS LESSON

1. Behavioral family management is designed to:

A. Increase family stress so as to identify sources of conflict among family members

B. Encourage families to openly reject patient members who display social withdrawal, disruptive behavior, or apathy, and do so without guilt, even if this means rehospitalization

C. Educate family members about the patient's disorder, enhance communication skills, improve problem-solving skills, and reduce the so-called EE (expressed emotion) attitudes that reduce the probability of sustained clinical improvement

D. Stir up guilt, anxiety, and even depression among family members to motivate them to be more helpful to the sick member

2. In the Camarillo State Hospital study, it was shown that:

A. Holistic therapy, consisting of art therapy, jogging, and meditation, had no positive effect whatsoever

B. Social skills training produced a significant improvement in the ability to deal with novel and different life experiences nine months after training, whereas holistic therapy only produced symptom improvement during the period of hospitalization

C. Holistic therapy was more effective than social skills training in teaching patients how to deal with real life situational problems after discharge

D. Both holistic and social skills training were shown to be worthless as rehabilitation procedures

over, please...

3. Which of the following statements about social skills training is correct?

A. The attention-focusing model depends on the patient's ability to attend to relatively complex training situations that last at least 30-90 minutes

B. Role playing and assertiveness training have no place in social skills training since these methods always make symptoms worse

C. Well controlled studies have shown that chronic schizophrenic patients cannot learn functional social skills and maintain these skills over time

D. The problem-solving method of teaching social skills views interpersonal communication as a three-stage process which requires receiving, processing, and sending skills

4. Studies indicate that approximately what percentage of chronically mentally ill psychiatric patients fail to remain functional in the community for more than three years?

A. 15%

B. 35%

C. 55%

D. 75%

Directions in
Rehabilitation
Counseling

VOLUME 1 • LESSON 2

Post-Stroke Depression

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Directions in Rehabilitation Counseling

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EDITOR'S NOTE

Stroke, a cause of long-term disability as well as the third-leading cause of death, represents a major health problem in the United States. While the physical disabilities resulting from stroke are well-documented, only recently has investigation focused on emotional disabilities associated with this neurological disorder. As the authors discuss, it was previously assumed that depression was a reaction to impairments produced by stroke, rather than being an integral feature of the disease itself.

Although a stroke may occur at any age, the average age of onset is 60. Therefore, information provided in this lesson will be especially relevant for the rehabilitation practitioner working with a geriatric population, as well as for the geriatrician responsible for medical management of stroke patients.

Among the more noteworthy observations about depression of mood among stroke patients are: its frequency, its neglect in treatment, and the relationship between post-stroke depression and lesion location. Although studies indicate a 30-50% incidence rate, most stroke patients receive no rehabilitative treatment for their depression. Studies indicate the frequency and intensity of post-stroke depression are related to the area of the brain in which the lesion is located.

Management of post-stroke depression consists of assessment and diagnosis, medication, and counseling. Early diagnosis of depression, essential to the rehabilitative process, may be complicated as many stroke patients have impairments of comprehension and expression. "Pseudo-dementia," often produced by post-stroke depression, may further complicate diagnosis. Management also includes the judicious use of tricyclic antidepressants. If these medications prove ineffective, electroconvulsive treatments may be indicated. In addition to medication, psychotherapy (individual, family, and group) is essential in treating the depression and in managing the psycho-social adjustments to the residual impairments of stroke.

Introduction

Stroke, defined as a sudden nonconvulsive focal neurologic deficit produced by an insufficiency of blood to the brain,[1] is one of the major health problems in the United States. In addition to being **the third-leading cause of death** and a major cause of physical disability among the elderly, stroke also has serious repercussions on the emotional and intellectual functioning of those who survive.

Although the physical signs and symptoms of stroke have been extensively documented and studied over the years, only recently has there been added interest in the emotional consequences of stroke. Yet, investigation of the emotional disorders associated with stroke may not only further our knowledge of the sequelae of stroke but may also advance our understanding of the brain mechanisms involved in regulating mood and behavior.

Historical Background

The association between brain injury and mood disorders has been known for about a century. In 1904, Adolf Meyer described the "traumatic insanities" and postulated that they had a specific relationship to specific areas of brain injury.[2] **Bleuler reported persistent, refractory depression following stroke,** and Kraeplin discussed the etiological role of cerebrovascular disease in producing states of depression.[3,4] More recently, Roth suggested injury to certain brain areas may produce depression.[5]

Many clinicians, however, have assumed depression to be an understandable reaction to the impairments produced by stroke, rather than an integral feature of the disease itself. For example, Fisher[6] stated the brain is the most cherished organ of the body and injury to it would understandably lead to depression. **Systematic studies, however, tend to refute that assumption.** For instance, Folstein and Maiberger found **stroke patients were significantly more depressed than orthopedic patients with equal degrees of physical impairment.**[7] Finkelstein and associates reported that symptoms of clinical depression as well as failure to suppress cortisol were significantly more common in stroke patients when compared with a control group of patients with a variety of chronic medical illnesses.[8] Our studies have also found only a weak correlation between depression and severity of either intellectual or physical impairment.

Prevalence

Several studies have shown a 30 to 50% incidence of post-stroke depression.[9-16] Of 103 outpatients who were seen at varying intervals post-stroke, we found 30% were depressed.[9] Feibel and Springer reported a 26% incidence of depression in 91 outpatients seen six months after a stroke.[10] Our study of 103 hospitalized acute stroke patients revealed 47% were depressed, 27% with major depression and 20% with minor depression.[11] Sinyor et al. reported 49% of stroke patients admitted to a rehabilitation hospital had depressive symptoms.[12] In India, Haroon found moderate-to-severe depressive mood in half of 40 stroke patients.[13] From the United Kingdom, Ebrahim et al.[14] reported a 46% incidence of post-stroke depression, and Wade et al.[15] found that three weeks after their stroke, 22% of outpatients were depressed and another 11% were probably depressed. Finally, Collin et al. reported a prevalence of post-stroke depression in 42% of patients seen one and two years post-stroke.[16]

Symptomatology

Post-stroke depressions are phenomenologically similar to those seen in patients with depressions of functional origin (i.e., with no known neuropathology).[17] Patients with post-stroke depression experience sadness, hopelessness, guilt, difficulties in thinking and concentration, disturbances in sleep and appetite, as well as thoughts of death and suicide. As with functional depressions, we have identified clinical sub-types, such as major and minor depression. The diagnosis of post-stroke major depression is based on the existence of symptoms of major depression using DSM-III criteria.[18] The diagnosis of post-stroke minor depression is based on the presence of dysthymic depression using DSM-III criteria.[18] The two-year duration of symptoms for the diagnosis of dysthymic depression, however, is not required for the diagnosis of minor depression. Symptoms of both sub-types are listed in Table 1.

The assessment of symptoms and the diagnosis of depression can sometimes be difficult in stroke patients. For instance, in some patients the process of clinical interview can be hampered by aphasia. In fact, patients with aphasia involving moderate-to-severe comprehension deficits cannot be reliably interviewed at all, because the diagnosis of depression depends upon the patients' ability to communicate their feelings of sadness, hopelessness, etc. Thus, we have had to exclude such patients from our studies. Reliable methods to determine the existence of depression in patients with comprehension and expression impairments is one of the most important problems in the field of psychiatry. Also, physical symptoms of depression, such as disturbances of sleep and appetite as well as loss of libido, may occur in medically ill patients as a result of the illness itself, rather than as a concomitant feature of the depression. In cases where a reliable diagnosis cannot be ensured for various reasons, it may be useful to observe the patients for behavioral manifestations of depression and to try a therapeutic trial to see if improvement occurs.

TABLE 1
Clinical Syndromes Associated With Cerebrovascular Disease

	Major depression (N=41)	Percent with symptom	Dysthymic depression (N=41)	Percent with symptom
Clinical symptoms	Depressed mood	100	Depressed mood	100
	Diurnal mood variation	76	Anxiety, restlessness, worry	67
	Loss of energy	73	Diurnal mood variation	46
	Anxiety, restlessness, worry	73	Hopelessness	46
	Weight loss, decreased appetite	63	Loss of energy	43
	Early morning awakening	56	Delayed sleep onset	33
	Delayed sleep onset	56	Early morning awakening	26
	Social withdrawal	54	Social withdrawal	23
	Irritability	54	Weight loss, decreased appetite	15
Associated lesion location	Left frontal lobe		Right or left posterior parietal and occipital regions	

(*Psychosom* 26:769-778)

Duration

Based on a two-year longitudinal study of post-stroke depression, the untreated course of post-stroke depression is approximately one year in duration, after which it spontaneously remits.[19] Most patients with minor depression, however, continue to be depressed at two years post-stroke.[19] The duration of depression is related not only to the clinical sub-type of the stroke but also to the area of the brain affected. For instance, we recently found hemispheric infarcts (i.e., in the distribution of the middle cerebral artery) result in longer-lasting depressions than those involving the brain stem or cerebellum (i.e. in the distribution of the posterior circulation).[20] Whereas 80% of patients with depressions following hemispheric infarcts (primarily involving left frontal cortex or left basal ganglia) remained depressed at six months' follow-up, only 20% of patients with major depressions following brain stem/cerebellar infarcts were still depressed at six months' follow-up.[20] Those differences presumably reflect differences in underlying etiologies and mechanisms. Thus, post-stroke depression is not a unitary phenomenon. We have identified but two of the factors that influence the course of the disorder, depressive diagnosis and lesion location.

Relationship of Depression to Associated Variables

Lesion Location:

We have consistently found a strong association between the frequency and severity of post-stroke depression. Major depressions occur most frequently among patients with left frontal cortex and basal ganglia lesions.[21] In addition, the severity of depression, as measured by depression rating scales, is directly proportional to the proximity of the lesion to the left frontal pole. That relationship is true not only for patients with single lesions of the cortex,[21,22] but also for those with bilateral hemispheric lesions,[23] subcortical lesions,[21] and those who are left-handed.[24] In a recent study, we also reported **sub-cortical atrophy, as evidenced by increased ventricle-to-brain ratios, may be an important predisposing factor in the genesis of post-stroke major depression.**[25]

Physical Impairment:

The relationship between physical impairment and post-stroke depression is relatively weak compared to that between depression and lesion location. For instance, based on the correlation coefficient of depression and physical impairment scores, as measured by an activities of daily living scale, physical impairment can account for only 10% of the variance in depression scores, whereas lesion location can account for 50%.[22] In addition, the cause-and-effect nature of the relationship between depression and physical impairment is uncertain. **Recent data suggest once depression occurs, it interacts with physical impairment so the most depressed patients remain the most impaired and vice versa.**[26]

In another study of prognostic indicators of post-stroke depression, we found early impairment predicted impairment at two years rather than impairment predicting depression.[27] We have also seen **patients who have an in-hospital diagnosis of major or minor depression show significantly poorer recovery in activities of daily living at two years than do patients who are nondepressed in-hospital.**[28] Moreover, the disparity in recovery profile between depressed and nondepressed patients is in some cases manifest even after the depression has been alleviated. We have suggested **it may be due to a lack of motivation and initiative to participate in rehabilitative measures,** and once the opportunity for early recovery is lost, there may be long-term repercussions in physical recovery.

Intellectual Impairment:

The relationship between intellectual impairment and depression is also relatively weak compared to the relationship between depression and lesion location. As physical impairment does not seem to cause depression but instead interacts with it, so also intellectual impairment does not seem to cause depression. Once depression exists, however, it may have a negative impact on intellectual functioning. Evidence suggests post-stroke depressions may produce a "pseudo-dementia" or dementia of depression.[25,29] Thus patients with major depression perform significantly worse on cognitive tasks than do nondepressed stroke patients who have the same size and location of brain injury.[25] Additionally, over six-month follow-up, nondepressed patients show improvements in cognitive status, as measured by the mini-mental examination, whereas depressed patients show either no change or a slight worsening.[29] Recently, Kase and associates also reported on the existence of intellectual deficits in patients with post-stroke depression.[30]

Social Functioning:

Whereas the degree of premorbid social impairment does not influence the occurrence of post-stroke depression, the severity of depression significantly impacts the social functioning of patients during the recovery period.[31] Patients with the most severe in-hospital depressions have the most impaired social functioning at six-month follow-up. Feibel and Springer[10] reported significantly more depressed patients had reduced social activities than did nondepressed patients when seen six months after their stroke.[11]

Rehabilitative Treatment

Post-stroke depressions are amenable to therapeutic intervention. A double-blind treatment study conducted at our center with nortriptyline (Pamelor) showed that **tricyclic antidepressant to be significantly superior to placebo in alleviating the symptoms of post-stroke depression.**[32] (See Figure 1.) Recently, Reding and colleagues[33] also reported the results of a double-blind treatment study, which showed greater improvement in physical functioning in patients who were treated with trazadone (Desyrel) than in those who received placebo.[33] In a retrospective study, Finkelstein and associates reported **patients whose depression responded to antidepressant medication showed greater improvement in their activities of daily living than did patients who were nonresponders.**[34] The interesting implication of those studies is that treating post-stroke depression helps alleviate not only the emotional plight of stroke victims but also helps in accelerating the process of physical recovery. Those findings support our earlier-cited studies that demonstrate the significantly negative impact on long-term physical recovery in cases of post-stroke depression.[27,28] It is, therefore, important to recognize and treat post-stroke depressions in the early stages.

Our current approach to the rehabilitative management of post-stroke depressions consists of accurate diagnosis, medication, and counseling. The diagnosis of post-stroke depression is confirmed with a careful clinical examination that assesses patients for the affective, cognitive, and behavioral manifestations of depression. **Patients with depression are then begun on treatment with nortriptyline, regardless of the site of the lesion. We generally use nortriptyline because of our experience and familiarity with that particular tricyclic. Nortriptyline is the least likely of the tricyclic antidepressants to cause orthostatic hypotension, and because it usually has only mild anticholinergic and sedative side effects. Nortriptyline also has a well-documented range of therapeutic serum levels. That is important, because some patients, particularly the elderly, may develop higher-than-usual blood levels on a given dosage.** In order to minimize the orthostatic or sedative effects of nortriptyline, **we administer the full daily dose at bedtime.**

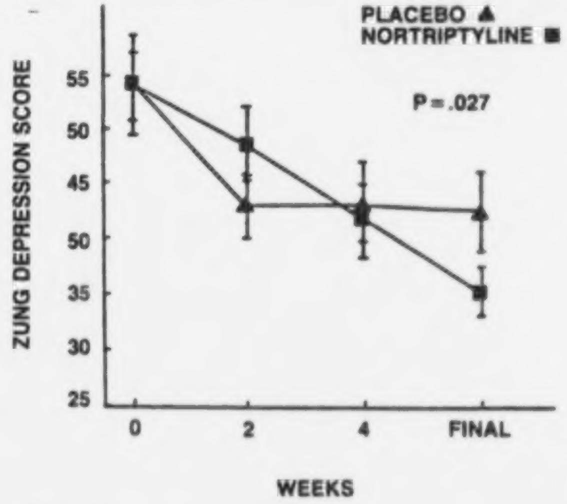

Figure 1. Zung depression scales for nortriptyline and placebo groups over time. Higher scores indicate more severe depression. Error bars represent ± S.E.M. P value is derived from repeated measure of analysis of variance of treatment
(*Lancet* 1:297–300, 1984)

We obtain pretreatment electrocardiograms on patients to check for relative contraindications to the drug, which include recent myocardial infarction, significant cardiac conduction anomalies, narrow angle glaucoma, and urinary tract obstruction. Nortriptyline can potentiate the effects of quinidine and procainamide (Procan) and may prolong the effect of warfarin (Coumadin). Poorly controlled seizure disorders may also be exacerbated. In our treatment study, three patients developed delirious states while on active medication, but in all three, delirium was reversed when the medication was discontinued. Most patients can be safely treated, however, with careful monitoring of the serum levels as well as the side effects. Moreover, untreated depression can be life-threatening in itself, with a high risk of suicide in some patients.

We begin most patients on 25 mg. at bedtime for one week and then increase the dose to 50 mg. for another week. After a week at 50 mg., we obtain a serum level. Serum level is checked earlier if the possibility or presence of side effects is observed. Further dosage adjustments are determined by the serum levels. We attempt to get most patients to the midpoint of the normal therapeutic range, which is between 50 and 150 ng/ml. Most patients require between 50 and 100 mg. a day to reach that level. Nortriptyline is one of the few drugs with a documented therapeutic window, so overshooting the upper limits of the therapeutic range may actually cause worsening of depression. However, it should be remembered that serum levels are a useful, but not necessarily precise, guide to therapeutic monitoring. Clinical response is the ultimate measure of appropriate therapeutic dosage.

Most patients respond within two to four weeks after reaching adequate dosage, though some may require up to six weeks of treatment. We do not usually consider treatment to be a failure until the patient has been on the therapeutic dosage for at least six weeks. **Successfully treated patients should be maintained on medication for at least six months before a gradual tapering of the medication is attempted.** Treatment may be reinstituted if any incipient signs of depression recurrence are present.

Patients who fail to tolerate nortriptyline may be treated with desipramine (Norpramin) or other tricyclic antidepressants. Nonresponders may be given a therapeutic trial with monoamine oxidase inhibitors or methylphenidate (Ritalin). Other rehabilitative treatment modalities such as electroconvulsive therapy, family therapy, and group therapy, have also been reported efficacious in managing post-stroke depression.[35-37] However, they have not been assessed using control double-blind methodologies.

In addition to treating the depression, the rehabilitation practitioner often needs to help the patient and the family cope with frustrations they may experience during the patient's physical recovery. Sometimes patients as well as their relatives set unrealistically high goals for physical recovery. **The rehabilitation specialist must assume an active role in the process of psychosocial adjustment to the residual impairment of stroke.** The vast majority of stroke patients, however, are relieved to see their depression recognized and willingly participate in the treatment process. Despite literature on the prevalence, severity, and the effects of post-stroke depression as well as research on the efficacy of treatment, **many studies indicate the majority of stroke patients**

receive no treatment for their depressions.[15,16] Feibel and Springer referred to such therapeutic neglect as one of the "great unmet needs of stroke patients."[38]

Future Directions

Ultimately, studies of depression in patients with stroke are needed to address the heterogeneity of mechanisms and etiology of these disorders. **Not all post-stroke depressions are the same,** and we will not have truly rational treatments until we understand the mechanisms at work. Recent advances in sophisticated neuro-imaging techniques, such as positron emission tomography (PET scanning) and magnetic resonance imaging (MRI) may facilitate this process. **Our studies with PET scanning indicate that a lateralized effect of stroke on serotonin (S2) receptors may play a role in the development of post-stroke depression.**[39]

The use of appropriate animal models could also permit a more rigorous and controlled study of various neurochemical and neurophysiologic alterations induced by stroke than is possible in human studies. Data from our model of stroke in the rat indicate a lateralized neurochemical and behavioral effect of stroke and that there are important parallels between the effects of stroke in the rat brain and in the human brain.[40,41]

The efficacy of various types of treatments for post-stroke depression is another possible productive area for future studies. In particular, the impact of treatment of depression on the intellectual and physical recovery and social functioning of patients with stroke merits greater exploration. Finally, we hope use of the lesion technique in investigating cerebral mechanisms of mood disorders may help clarify the relationship(s) between focal brain areas and specific mood disorders, and ultimately expand knowledge about the mechanisms of normal mood regulation.

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QUESTIONS BASED ON THIS LESSON

5. Which of the following statements is correct?

A. Post-stroke depression can be entirely accounted for as an understandable reaction to the impairment produced by stroke

B. In one study, orthopedic patients with physical impairment were shown to be more commonly depressed than post-stroke patients

C. The incidence of post-stroke depression is reported to be 30-50%

D. Depression in stroke victims is usually diagnosed and treated quickly and effectively today

6. Which of the following statements is correct?

A. The duration of post-stroke depression is related exclusively to the clinical subtype of the stroke

B. Hemispheric infarcts result in longer-lasting depressions than those involving the brain stem or cerebellum

C. Major depression seldom occurs in stroke patients with left frontal cortex and basal ganglia lesions

D. The severity of post-stroke depression is inversely proportional to the proximity of the lesion to the left frontal pole

7. According to Drs. Parikh and Robinson, which of the following factors seems to be an important predisposing factor in the genesis of post-stroke depression?

A. A life-long history of obsessive compulsive disorder (OCD)

B. Alcoholism

C. Widowed or divorced single marital status

D. Subcortical atrophy, as evidenced by increased ventricle to brain ratios

over, please...

8. Which of the following statements about post-stroke depression is correct?

A. In stroke patients the relationship between intellectual impairment and depression is much stronger than the relationship between depression and lesion location

B. Post-stroke patients with major depression usually perform worse on cognitive tests than do non-depressed post-stroke patients

C. Post-stroke depression impedes neither rehabilitation efforts nor social functioning

D. Post-stroke depression is refractory to all treatment

Directions in
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VOLUME 1 • LESSON 3

Stress "Addiction": Causes, Consequences, and Cures

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Directions in Rehabilitation Counseling

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EDITOR'S NOTE

Unmanaged stress poses a serious health risk, contributing to and/or exacerbating numerous disabling conditions. Rehabilitative health care is complicated by poorly defined concepts, by inadequate intervention strategies, and by the "addictive" qualities of stress.

The link between the psychobiological responses to stress and health is an age-old observation. Centuries ago, physicians noted that intense emotional states and a variety of behavioral patterns, including excessive work involvement, characterized people who developed coronary heart disease. More recently, Cannon's studies showed that the reaction to the stress of acute fear involved a marked increase in sympathetic nervous system activity and an outpouring of epinephrine. Other studies have shown myocardial infarction associated with excessive norepinephrine at myocardial nerve endings even in the absence of significant coronary artery occlusion.

The "Type A personality" with his/her vulnerability to cardiovascular disease, presents a number of dominant personality characteristics: unrealistically high ambition, persistent vigilance, hyperactive responsiveness, low level of frustration tolerance, and a constant need to perform. These features are, of course, only a few manifestations of a much more complex behavioral pattern which has been shown statistically significant as a risk factor for heart disease. Recent evidence suggests that only certain aspects of type A behavior, particularly anger and hostility, are relevant to the prediction of coronary heart disease.

Questions remain. Why do certain individuals perpetually seek stress and react to it in the very way that is so detrimental to their over-all psychological and physical well-being? The author poses the possibility that there may be pharmacologic dependency to epinephrine and other central nervous system mediators. The individual is, in turn, driven to repeatedly seek situations that will increase the amount of these substances in the body. Only then can he or she feel comfortable. When the person is not exposed to stress, serious dissatisfaction or depression may ensue. Is this a learned pattern of behavior, with the establishment of epinephrine habituation a kind of within-the-body drug dependency state? Could there actually be physiological changes of an addictive nature?

While there are a few definitive answers, several intervention strategies are being successfully implemented. Behavior modification, using stress-inoculation techniques, has proved effective in reducing heart disease risk. Propranolol and other beta-blockers have helped reduce recurrent heart attacks and myocardial infarction. Further interdisciplinary research is needed, however, to extend and clarify behavioral and pharmacologic methods for interrupting the stress-dependency cycle.

The Need for Definition

Stress has become the modern metaphor, the buzz word of the 1980s. Despite its ubiquitous popularity, however, it remains very difficult to define–at least to a scientist's satisfaction. Much of the confusion stems from the fact that stress means or represents something different for each of us.

Customarily, we think of stress as an external noxious event producing undesirable physiological responses that may result in various illness syndromes. The term was coined, so to speak, only a few decades ago by the brilliant Canadian investigator **Hans Selye, who viewed it as a "nonspecific" response of the organism to any demand for change.**[1] Selye's studies showed that **when laboratory animals were subjected to any unpleasant stimulus or challenge, very consistent, almost stereotyped responses were observed. These appeared to be due to stimulation of the pituitary-adrenocortical axis, with resultant increased hormone levels that produced macroscopic and microscopic pathologic changes in the gastric mucosa, lymphoid tissues, and adrenal cortex**.

Whether the stressor took the form of extreme heat or cold, severe frustration, loud noises, bright lights, or exhausting muscular exercise, the same acute changes were observed. Continued exposure to stress led to the appreciation that there appeared to be **three phases** to this response. The first was termed the "**alarm reaction,**" which was viewed as a call to arms of the body's defenses and was characterized by marked stimulation of the sympathetic nervous system and pituitary-adrenocortical responses. If the stress was persistent, a "**stage of resistance**" appeared to ensue in which the body's adaptive defenses were maintained. Finally, prolonged stress resulted in a "stage of exhaustion" and death. Selye termed this tripartite response the "general adaptation syndrome." Pathologic changes in various tissues and organs observed during various phases of the response to stress appeared identical to morphological and microscopic findings seen in such clinical disorders as hypertension, coronary heart disease, peptic ulcer, and rheumatoid arthritis. Selye reasoned that such disorders in humans might similarly be caused by stress; he labeled them "diseases of adaptation."

However, the term "stress" quickly attracted all sorts of interest, and moved out of the domain of endocrinology and biology, as it became increasingly adopted by psychiatrists, psychologists, behavioral scientists, rehabilitation practitioners, sociologists, and eventually the general public. In the vernacular, it appeared to be synonymous with distressing emotional factors. Others used "stress" to denote the pathologic results of distress, such as a peptic ulcer or heart attack. Eventually the term embraced not only the offending stimulus (stressor), as well as the physiological and biochemical responses to that stimulus, but also resultant disease states. The definition of "stress" had become so complex that one commentator complained that "stress, in addition to being itself and the result of itself, is also the cause of itself."[2]

Selye later discovered that "conditioning" the animal with dietary or hormonal manipulation could produce different types of pathology, leading to the suspicion that the effects of stress were not predictably uniform. As refinements in endocrine techniques became more sophisticated and animal research was extended to clinical experimentations, it became increasingly apparent that, far from being

nonspecific, the response to stress in humans was highly variable and personalized. In fact, there appeared to be a whole repertoire of neurohumoral secretions, which varied from individual to individual or even in the same individual at different times. **As new hormones, such as prolactin and melatonin, could be measured more accurately, it was found that they, in addition to pituitary trophic hormones other than ACTH, were also significantly affected by stress. This was particularly true in the case of the endorphins, whose secretion during stress paralleled that of ACTH** and appeared to be governed by identical adrenocortical feedback mechanisms.

To further complicate matters, it became apparent that stress in humans involved not only the acute life-threatening or irritating stimuli studied in laboratory animals but also a host of chronic, repetitive, irritating hassles that occur in daily life, as well as less easily quantifiable chronic psychosocial factors, such as bereavement, loneliness, crowding, and chronic depression. In the past few years, these factors have assumed increasing importance and appear to be linked with a higher incidence of malignancy and a host of other disorders characterized by impaired immune-system responses.[3,4]

Stress, Behavior, and Health: An Ancient Observation

In the above discussion, we have dealt with the model of stress as a function fo the organism's response to external influences. Over the past three decades, however, attention has been directed to the realization that **stress can also be self-generated as a consequence of certain behavioral characteristics or traits**. The prime example of this is seen in the individual with Type A coronary-prone behavior pattern, one component or consequence of which may be inadvertently self-induced epinephrine habituation or addiction.

The close relationship of emotions, personality, and cardiovascular disturbances is certainly not a new observation.[5] Almost 2000 years ago, Celsus noted that "fear and anger, and any other state of the mind, may often be apt to excite the pulse." William Harvey commented in 1628: "Every affection of the mind that is attended either with pain or pleasure, hope or fear, is the cause of an agitation whose influence extends to the heart." John Hunter, who during the 18th century elevated surgery from a mechanical trade to an experimental science, suffered from angina. Being a keen observer, he complained: "My life is in the hands of any rascal who chooses to annoy and tease me." That statement turned out to be somewhat prophetic since, in fact, an argument did precipitate his death from a heart attack. Napoleon's physician, Corvisart, wrote that heart disease was due to the "passions of the mind," among which he included anger, madness, fear, jealousy, terror, love, despair, joy, avarice, stupidity, and--last but not least--ambition.

One hundred and fifteen years ago, von Dusch, a German physician, first called attention to the fact that excessive involvement in work appeared to be the hallmark of people who developed coronary heart disease. Toward the end of the last century, Sir William Osler succinctly but accurately described the coronary-prone person as a "keen and ambitious man, the indicators of whose engines are set at 'full speed ahead.'" In the 1930s, the Menningers suggested that coronary heart patients tended to exhibit strongly aggressive behavior, and a decade later, Flanders Dunbar, who introduced the term "psychosomatic" into American medicine,[6] characterized such persons as being authoritarian with an intense drive to achieve unrealistic goals.

More Recent History: The Cardiovascular Response to Stress

Attempts to study the mechanisms whereby emotional states could produce cardiovascular damage or sudden death received tremendous impetus as a result of the investigations of Walter Cannon at Harvard in the early part of this century. **Cannon's studies demonstrated that response to the stress of acute fear resulted in a marked increase in sympathetic nervous system activity and an outpouring of epinephrine, which prepared the animal for lifesaving "fight or flight."**[7] His later studies of the mechanism of "bone pointing" or "voodoo" death also implicated a flooding of the system with epinephrine as the most likely cause of fatal arrhythmia.[8]

Selye's formulation of the stress concept in the late 1940s provided further insight into the role of pituitary and adrenocortical factors in modulating cardiovascular responses to stress. His subsequent research included the experimental production of "metabolic cardiac necroses," in which direct biochemical injury to heart muscle rather than occlusion of the coronary vessels was the causative factor.[9]

More recently, it has been observed that stress may also lead to accelerated atherosclerosis and coronary occlusion because of elevated cholesterol, triglycerides, and free fatty acids, increased platelet adhesiveness, polycythemia, accelerated blood clotting, increased fibrinogen, haptoglobin, plasma seromucoids, etc. We have also become increasingly aware of the important role of stress-induced coronary vasospasm in the production of clinical symptoms and disease.[10] Even more significant has been the identification of **myocardial infarction in the absence**

of significant coronary occlusion due to the excessive release of norepinephrine at myocardial nerve endings. This has now been demonstrated to produce a specific type of myocardial damage which can be recognized under the microscope and appears to be identical in laboratory animals, as well as in humans who have succumbed to sudden cardiac death as the result of an acutely stressful situation.[11]

The Type A Personality

Our current appreciation of coronary-prone behavior and its possible relation to epinephrine addiction is due almost entirely to the ground-breaking efforts of Friedman and Rosenman.[12] These investigators noted that **conventional risk factors--such as elevated cholesterol, hypertension, and smoking--accounted for less than half the cases of heart attack in their practice.** They were intrigued by the fact that two thirds of the heart attacks in the United States occurred in men, although in Mexico the incidence was 50-50. The same equal split appeared to exist in southern Italy but not in northern Italy, where the ratio was four men to every woman. Such a disparity did not appear to be due to any difference in diet or environmental factors and on further analysis appeared to be more related to certain social, cultural, and behavioral attitudes that might best come under the heading of "maleness." **Such individuals, labeled Type A, exhibited certain overt characteristic activity patterns, including:**

1. **Self-imposed standards that are often unrealistically ambitious and are pursued in an inflexible fashion.** Associated with this is **a need to maintain productivity in order to be respected,** a sense of **guilt during vacations** or relaxation, **an unrelenting urge for**

recognition or power, and a **competitive attitude that often creates challenges even when none exist**.

2. Certain thought and activity styles, characterized by **persistent vigilance and impulsiveness**, usually resulting in the pursuit of several lines of thought or action simultaneously.

3. **Hyperactive responsiveness, often manifested by a tendency to interrupt or abruptly finish a sentence in conversation,** usually in dramatic fashion by varying the speech, volume, or pitch or by alternating rapid bursts of words with long pauses for emphasis, indicating intensive thought. Type A's often nod or mutter agreement or use short bursts of laughter to obliquely indicate to the speaker that the point being made has already been anticipated.

4. A tendency to have **unsatisfactory interpersonal relationships, due to the fact that Type A's are usually self-centered, are poor listeners,** often have an attitude of bravado about their own superiority, and are **easily angered or frustrated if their wishes are not respected** or their goals are not achieved.

5. **Increased muscular activity** in the form of gestures and motions and facial activities, such as grimaces, gritting and grinding of the teeth, or tensing of jaw muscles. Often there is clenching of the fist or perhaps pounding with a fist to emphasize a point. Fidgeting, tapping the feet, leg shaking, and playing with a pencil in some rhythmic fashion are other favorites.

6. **Irregular or unusual breathing patterns with frequent sighing,** produced by inhaling more air than needed during speaking and then releasing it during the middle or at the end of a sentence of emphasis.

Type A's tend to be very competitive, are usually **rushed**, and, as a consequence, are rapid when eating or talking and in most other activities. They generally try to do too many things at once, are **more concerned with quantity than with quality of effort**, are frequently preoccupied with what they are going to do next, and tend to have few interests outside of their work. Recent evidence suggests that certain aspects of type A behavior–in particular anger, aggression, and hostility–are predominant as regards their predictive power for coronary heart disease.

I have gone into some detail in describing Type A characteristics simply to emphasize that it is **a complex overt behavioral pattern** that can be identified only by personal observation. In clinical practice, its evaluation requires a structured personal interview conducted by a trained investigator using standardized challenges designed to elicit the characteristics noted above. It is almost impossible to detect in the very sick, bored, depressed, or detached person. Accurate assessment therefore requires considerable expertise, making large-scale studies relatively time-consuming and costly.

A variety of questionnaires have been devised to detect such aspects of Type A behavior as competitiveness, ambition, impatience, hostility, preoccupation with work, and a constant sense of time or urgency. The most commonly used instrument, **the Jenkins Activity Survey, detects three main behavioral syndromes: (1) hard-driving temperament, (2) intense job involvement, and (3) speed and impatience.** Although the three scores derived correlate with the total evaluation, they are not necessarily related to one another, and the **overall accuracy is limited when compared with a structured personal inter-**

view. It should also be emphasized in evaluating any self-administered questionnaire that Type A individuals are often unaware of many of their behavioral patterns or will deny them. No single Type A individual should necessarily be expected to exhibit all the above characteristics; conversely, some Type A traits can be found in Type B or Type C (Type B with anxiety) subjects.

Studies of Heart-Disease Risk

As our understanding of this complex subject has expanded, it seems likely that certain components of Type A behavior–such as time urgency, latent hostility, and aggressiveness–may be found to have a greater predictive significance for coronary heart disease, increased norepinephrine secretion patterns, vascular hyperreactivity, or other phenomena that mediate stress-induced myocardial damage. Despite any imprecision in its quantification, however, Type A coronary-prone behavior has been unequivocally established as an independent risk factor for heart attack as significant as any other known entity.[13] The observation of increased catecholamine excretion in such persons and the known deleterious effects of such agents on the myocardium have prompted many of us to reevaluate and question current concepts of the pathogenesis of coronary heart disease.

In 1982, the disappointing results of the seven-year, $115 million MRFIT study were published in the *Journal of the American Medical Association*.[14] MRFIT is an acronym for Multiple Risk Factor Intervention Trial, which was designed to show the beneficial effect of stopping smoking and lowering cholesterol and blood pressure. However, patients in whom the desired behavioral and physiological changes

were achieved did not receive any significant protection. In fact, the hypertensives treated with diuretics had a higher incidence of heart attacks than did controls (possibly because of a tendency toward hypokalemia, which potentiated adrenergic effects).

In contrast, over the same period, two other studies designed to reduce the likelihood of recurrent heart attacks were *so successful* that they were *halted* before their completion so that controls would not be denied the benefit of intervention. One was **a trial using techniques to reduce damaging Type A behavior;**[15,16] the other was the NHLBI study of almost 4000 patients, in which it was found that **after only two years the administration of propranolol (Inderal) had reduced mortality by 26%.**[17] **Both findings again strongly suggest that stress-related sympathetic nervous system drive and catecholamine secretion are the major culprits in coronary heart disease.** Behavioral modification is aimed at turning off the epinephrine-norepinephrine spigot, and propranolol and other beta-blockers appear to blunt the damaging effects of such agents on the cardiovascular system. The benefits of behavioral modification have since been confirmed in other studies, and the protective effects of other beta-blockers in preventing heart attacks have now been demonstrated for almost every such agent tested for this purpose.[18-21] As a consequence, some authorities have suggested that beta-blockers be administered to all heart-attack patients provided there are no contraindications.

The Evolutionary Point of View

Now, from an evolutionary or teleologic viewpoint, stimulation of the sympathetic nervous system and a jolt of epinephrine made a lot of sense for primitive man. As a consequence, the pupils dilated so he could see better and glycogen stores in the body were quickly broken down to elevate the blood sugar and provide additional energy. Blood was directed away from the gut, where it was no longer needed for digestive processes, and shunted to the muscles of the arms and legs so he could fight better or run faster. The blood pressure rose, and there was an increased flow of blood to the brain to improve cerebral function–in short, a whole host of adaptive changes occurred to prepare our ancestors for life-preserving "fight or flight."

However, **the nature of stress for modern man is quite different.** It is not an occasional confrontation with a sabertooth tiger or pack of wolves but, rather, problems at work or at home, financial difficulties, or simply getting stuck in a traffic jam on the way to a vital appointment. Furthermore, such challenges and provocations occur not once a fortnight but many times during daily life. **The tragedy is that our bodies still respond in the same old archaic fashion**. Unfortunately, that release of epinephrine is now not only purposeless and inappropriate but actually harmful, with lethal potential for causing a heart attack, sudden death, stroke, hypertension, peptic ulcer, diabetes, and a variety of other disorders that might appropriately be labeled "disease of civilization."

Stress Habituation

It seems plausible that the Type A coronary-prone person may have become habituated to stress, a learned, fixed response with obviously damaging consequences; there is even a remote chance that physiological changes may establish an actual addiction to

epinephrine or other central nervous system substances. Support for this comes from Solomon's "opponent-process theory of motivation,"[22,23] which basically asserts that man is by nature susceptible to various habits and addictions that provide a sense of pleasure. However, when man is deprived of the thing that is craved, an opposing emotional state often results. The exhilarating feeling of being in love can change to melancholy if one can no longer be with the object of one's affection. People who are hooked on skydiving may become severely depressed if the weather interferes with their activities for a few days. Similarly, withdrawal from cigarettes, alcohol, narcotics, tranquilizers, or recreational drugs often produces emotional states opposite from the sensations those substances induce.

The Learned Response

Because of his/her psychological condition, the Type A individual may unconsciously seek ways to get those repeated surges or highs. That could come in the form of constructing little contests, like getting to the airport a few minutes before takeoff, turning a car trip into a race by establishing certain times at which check points must be reached, or purposely leaving a desk untidy or delaying an assignment to the last minute–just so there will be some sort of contest or last-minute challenge. Deprived of that epinephrine stimulus, the Type A individual is apt to be irritable and depressed. Thus, recuperating from a heart attack by spending three weeks on a deserted beach might be a perfect prescription for one person but deadly for some Type A's, who could be in a state of agitation in a matter of hours. Beta-blockers may help to alter Type A behavior by blunting the unconscious self-induced production of epinephrine and norepinephrine, diminishing their dependency-producing potential.

That this may become a learned or fixed response is suggested by other studies which show that **Type A individuals, even while under anesthesia for coronary bypass procedures, exhibited a greater increase in systolic blood pressures than did Type B controls. They also had more arrhythmias and other complications, and 50% longer hospital stays.**[24] Thus, **repetitive or exaggerated sympathetic responses may result in a state that tends to perpetuate this type of behavior.** It remains to be seen whether other stress-related neurohumoral agents, such as serotonin or beta-endorphin, also have a potential for inducing habituation or addiction. Such a possibility is suggested by the finding of **elevated metenkephalin in compulsive persons who habitually mutilate themselves and those who show profound disturbances in appetite manifested by bulimia and anorexia.**[25]

The Role of Addictive Mechanisms

If one can become pathologically dependent on stress or epinephrine, it is possible that research on addiction or habituation to other substances, such as cocaine or marijuana, would provide useful information. Like stress, drug habituation and addiction are difficult to define, but **an important characteristic common to both appears to be lack of control**. Addictive behavior appears to be mediated by changes in neurotransmitter activity in the brain. The rate at which neurons fire is determined by the concentration of neurotransmitters at the synapse. The higher the concentration, the more rapid the transmission and the more intense is the resultant feeling or sensation. It is possible that addiction occurs because people either repeat some behavioral pattern or ingest various addictive substances that elicit a desired mood.

Under normal circumstances, following their release by excitation over neural pathways, neurotransmitters are pumped back into the presynaptic neuron, where they are stored for further use. Certain drugs appear to interfere with this pumping mechanism. As a consequence, the neurotransmitter remains at the synapse and its presence in higher concentration results in more rapid neurotranmission and enhancement of the resultant sensation desired. Heroin and cocaine may induce their euphoric mood by such a mechanism.

One factor that appears to be common in the addictive personality as well as in Type A coronary-prone behavior is a poor self-image. A method of dealing with such feelings of worthlessness is to seek ways of changing or elevating this unpleasant mood. The Type A individual may accomplish this by submersion or preoccupation in excessive work. For others, the driven dependency compensation may take the form of overeating, fasting, chocolate binges, jogging, skydiving, smoking, drinking, gambling, or the use of various recreational drugs.

Obviously, any form of habituation or addiction represents a two-edged sword. While initially providing gratification, it can ultimately prove harmful or lethal. A prime example of this is the jogger who persists in running despite any number of resulting orthopedic problems that would normally preclude such activity because of pain. The confirmed alcoholic with cirrhosis, the cigarette smoker with emphysema or Buerger's disease, and the compulsive gambler already in debt are other instances. Some people may be unaware of the harmful aspects of their addictions or, alternatively, persist in attempting to satisfy their cravings despite a knowledge of the dire consequences.

Stress-Transmitting Mechanisms

Those people who seem to seek repeated or perpetual epinephrine hyperactivity appear to fit this mold. A variety of significant strategies and approaches are being explored to address the problem. Currently, attention is being focused on central nervous system structures and mechanisms that initiate or transmit the stress signal. **Preliminary evidence suggests that both heart rhythm and force of contraction are regulated by the same centers in the frontal cortex of the brain that stimulate sensory reception during acute fear.** If the nervous system pathways from the frontal cortex to the brain are severed or temporarily blocked by freezing, experimental animals that would normally succumb to ventricular fibrillation during severe psychological stress are protected. **The search is on for some pharmacologic agent that might provide the same benefits.** As mentioned previously, behavioral modification by stress inoculation techniques has proved dramatically effective in preventing recurrent heart attacks in Type A coronary-prone patients. Similarly, propranolol and almost every other beta-blocker studied have proved effective in reducing recurrent heart attacks, as well as sudden death in patients with myocardial infarction.

Finally, we have previously suggested that **Type A and coronary-prone behavior may not be synonymous** and that **certain components--such as aggression, competitiveness, latent hostility, and time urgency--may be more predictive for coronary events.**[5] **Many persons with apparently flagrant Type A behavior appear to thrive on stress and lead long, healthy, productive lives.** Certain symphony conductors, performing artists, and entertainers represent good examples. **Analysis of such stress-resistant personalities suggests that in general such persons are in control of their activities, have a strong commitment to what they are doing, and enjoy or respond to challenges rather than being overwhelmed by them. Recent research has challenged the conventional concept that autonomic responses to positive and negative emotions are the same.** A recent study reported not only that autonomic activity could be differentiated between such states but also that even negative emotions (such as sadness, fear, and disgust) could be further differentiated by simply contracting facial muscles into the expressive forms associated with these affective states.[26]

Similarly, **persons who are productive, who have pride of accomplishment, and who derive pleasure from doing something they enjoy that benefits others appear to have health patterns different from those of Type A counterparts who are constantly frustrated by self-imposed unrealistic standards and goals.** Such behavior, which Selye termed altruistic egoism, makes sense from an evolutionary or teleologic viewpoint. When primitive man was faced with a natural disaster, such as a flood or attack by a pack of wolves, banding together with others to combat such life-threatening situations had survival value. Consequently, nature tended to perpetuate the survival of a species so motivated. From another viewpoint, the craving for an epinephrine-induced high may no longer be required for persons whose self-esteem has been significantly raised by activities that are productive and fulfilling.

While stress is a complex phenomenon, it is apparent that many of its disastrous consequences are mediated by the release of neurohumoral chemicals related to epinephrine as well as various small brain peptides, either as a response to external stimuli or as unappreciated consequences of self-induced secretion. Such agencies have now been demonstrated to have a profound effect on the cardiovascular system, as well as on immune competency, and play a significant role in the development of hypertension, coronary heart disease, cancer, and a variety of infectious disorders. Further insight into behavioral and pharmacologic methods of interrupting this vicious cycle of stress dependency offers great promise for the treatment and cure of many common "diseases of civilization."

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QUESTIONS BASED ON THIS LESSON

9. Which of the following statements is correct?

A. The organism's response to stress is entirely nonspecific

B. Stress responses in humans are highly variable and personalized

C. The relation between emotional reactions to stress and cardiovascular disease was discovered during the past hundred years

D. Myocardial infarction cannot occur in the absence of significant coronary artery occlusion

10. Stress addiction, as a learned fixed response, may have implications for which of the following disabling conditions?

A. Compulsive personality disorders

B. Eating disorders (e.g., anorexia, bulimia)

C. Diabetes, hypertension, peptic ulcers

D. All of the above

11. Which of the following statements is correct?

A. In the MRFIT study, hypertensives treated with diuretics had a much lower incidence of heart attacks than controls

B. The administration of propranolol increased the mortality rate among patients with heart disease by 26%

C. The stress-related sympathetic nervous system drive and catecholamine secretion are probably the major culprits in a significant number of cases of heart disease

D. Decreased muscular activity is characteristic of Type A behavior

over, please...

12. According to Paul J. Rosch, M.D., the Type A personality, prone to heart disease, seeks out stressful situations because s/he:

A. Has become habituated or addicted to the stimulation of catecholamines and their effect on the CNS and finds it intolerable to be without that influence

B. Is unconsciously self-destructive and suicidal

C. Lacks insight into his/her behavior patterns

D. Has a unique talent that s/he is committed to fulfilling

Directions in Rehabilitation Counseling

VOLUME 1 • LESSON 4

Visual-Perceptual Rehabilitation in Psychiatric Patients

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EDITOR'S NOTE

There are three known basic information pathways associated with vision. One informs about an object's shape and hence its identity; a second about color; and the third, visuo-spatial management, about location of objects in space and of the observer, as well as the facility to visually adapt to movement. Defined as a self-selecting, self-directing action in search of information with sensory feedback, visuo-spatial perception has two characteristic forms: (1) central vision, needed for attention to form, such as close detail, and (2) peripheral vision, dealing with the larger environment, scanning the wide distances of space.

In a recent controlled study, Drs. Flach and Kaplan, in collaboration with members of the psychiatric and psychology staff at New York Medical College, confirmed a high incidence of visuo-spatial management dysfunction in patients diagnosed with schizophrenia and affective disorders, a condition termed the Kaplan-Flach syndrome. Previously, they had reported similar observations in an uncontrolled study: a 66.6% incidence of significant impairment among such patients. This visuo-spatial dysfunction was most marked among those patients who had been ill for more than six months and in whom social withdrawal, academic failure, and employment difficulties were significant problems. Since sustained recovery from illness depends more strongly on the patient's ability to resume an effective life style that on diagnostic categorization or psychopathology, these findings have strong implications for overall rehabilitation efforts.

The implications of visuo-perceptual impairments for rehabilitation occur on several levels: psychological, social, academic, and vocational. Visuo-spatial management patterns may well reflect and influence thought patterns, which clearly impact a patient's adjustment. These patterns also appear related to the ability to carry out the tasks demanded of various jobs. For example, the salesperson must have adequate peripheral vision, whereas the microbiologists needs adequate central vision. Ideally, both forms of information gathering should be available to an individual, with one form being somewhat more dominant. Fixation in either direction may handicap academic and employment performance. Rehabilitation strategies which correct rigidity, instability, and/or other deficiencies in visuo-spatial management can lead to improved work performance and vocational stability.

As presented in this lesson, methods for determining the presence or absence of visuo-spatial management disorder are relatively simple. Most importantly, these impairments are functional in nature, not organic, and are amenable to correction by yoked prisms, with or without special visual training as indicated. For some individuals, perceptual disabilities may date to early childhood, having caused them significant psychosocial, developmental, and learning problems throughout life. For others, visuo-spatial management impairments may be part of their reaction to situational stress, with a failure to self-correct once the stressful conditions are resolved.

Visuo-Spatial Management Disorder (The Kaplan-Flach Syndrome) in Psychiatric Patients

When the psychobiological model of mental health and illness is used in evaluating psychiatric patients, psychological and physiological processes often become practically indistinguishable from one another. Stress influences bodily functions even as the biological matrix in which emotions are experienced affect how everyone traverses a wide variety of stressful moments throughout life. For example, the developing child, exposed to a set of environmental conditions that may favor or thwart healthy growth, inevitably is influenced by these conditions on a physical level. The child, in turn, perceives and reacts to them physiologically as well as psychologically.

Piaget, in his remarkable observations on a development of the child's intelligence and capacity to master himself and the environment, has described **the stepwise process of learning and the expansion of the ability to learn that serves as a vital part of every human being's ability to adapt to changing circumstances and new challenges.[1,2] This ability to adapt may determine whether a person who has the potential for psychiatric illness (e.g. an affective disorder or a form of schizophrenia) will manifest symptoms of that disorder at some point in life.[3,4]** More specifically, the integrity of the sensory systems, through which information obtained from the external milieu enters and is processed by the central nervous system, is a central part of such adaptive mechanisms. **Foremost among these is the visual system, which is intimately involved with such basic functions as orienting oneself in space, self-image, and such complex tasks as reading and writing. The visual system influences not only what one thinks but probably**

how one thinks.

Bellak[3] has discussed how the presence of attention-deficit disorder (ADD), reflecting minimal brain damage, might cause psychopathologic changes in otherwise healthy persons and might color the way certain defined conditions, such as the schizophrenias, might manifest themselves. He emphasized that the presence of ADD could influence the therapeutic strategies selected by the treating physician. For example, patients with ADD respond poorly to phenothiazines and rather well to small doses of heterocyclic antidepressants or even lithium. Implicit in his presentation, however, was the assumption that the signs and symptoms of ADD were rooted in biological damage to the central nervous system, and distinct from etiological elements central to affective disorders or the schizophrenias. But **what if, among patients with psychiatric disorders, there are basic visual-perceptual difficulties that may contribute to the illnesses, shape their course, or affect how the patient experiences the disorder; that are largely functional, rather than organic; and that are readily diagnosed and receptive to treatment as part of the overall rehabilitation regimen?**

In our first systematic study of visual-perceptual function in psychiatric patients, which we reported in *Comprehensive Psychiatry*,[5] we found that in a series of 57 subjects, 48 of whom manifested clearly diagnosable psychiatric disorders, **32 of the patient group (66.6%) showed moderate to severe impairment in visual-perceptual function. This finding was in contrast to an expected incidence of about 9% in the general population.[6] Moreover, the patients showing such dysfunction were, by and large, diagnosed as having major depressive disorder, recurrent (DSM-III 296.3), schizophrenic disorders (295.3**

and 295.6), and alcohol dependence (303.9). When the data were further analyzed, it was apparent that **visual dysfunction was much more notable among patients whose conditions could be considered chronic--of six or more months' duration--and in whom social withdrawal, employment difficulties, and academic failure were significant features**.

In 1989, in collaboration with the psychiatry and psychology staff of the Psychiatric Institute, New York Medical College, Valhalla, New York, we completed a controlled study in which 57 patients diagnosed with schizophrenia or affective disorders were compared with 60 control subjects. Not only were our earlier findings confirmed--the patients differed from the controls with a high degree of significance--but it was actually possible to differentiate patients diagnosed as schizophrenic from those with affective disorders on the basis of the assessments for visuo-spatial disorder.

Levels of Visual-Perceptual Dysfunction

In evaluating visual-perceptual function in both studies, each patient was examined using standard optometric techniques to determine the following dimensions of visual ability: (1) fusion, (2) phoria, (3) ductions, (4) K-fraction, (5) pursuit tracking, and (6) vergence tracking. **Three types of visual dysfunction were identified. Level I, "vergence dysfunction," is considered to be present when the duration of the convergence or divergence of eye movements is too large or too small in reference to the object of regard. There is usually a focusing insufficiency. Level II dysfunction, "spatial organization dysfunction," is the perceptual loss of visual constancy, resulting from the selec-**

tive reduction of depth to a two-dimensional field in addition to the difficulties noted in Level I dysfunction. Level III dysfunction, "spatial orientation dysfunction," represents a loss of the developmental interaction between the visual spatial orientation and the body spatial orientation, resulting in a serious discrepancy between vision and position sense. In addition to the deficiencies shown among patients with Levels I and II dysfunction, those in level III also show an inability to track in pursuit while standing up, vergence tracking without simultaneous movement, and, in severe cases, complete shutting down of the visual systems.

The inability to track effectively, seen among patients with Level III dysfunction, was previously reported in schizophrenic patients. Mialet and Pichot[7] stated that such patients might have central nervous system imbalance reflected in abnormalities in eye-tracking movements–in particular saccades, the fast, ballistic movements that bring the fovea to the target. Holzman et al.,[8] in similar studies, described the phenomenon as a failure of normal inhibiting mechanisms indicative of a broader neurophysiological disturbance in schizophrenic patients. Our studies position such abnormal saccades within the framework of an overall visuo-spatial management disorder, giving them meaning that goes beyond their previously considered value as a genetic marker.

Implications for Rehabilitation

If, as our studies indicate, serious a visuo-spatial management disorder exists among a significant number of patients suffering with chronic, recurrent states of depression as well as certain forms of schizophrenia, what questions does such a correlation raise? Since the nature of this disorder is not fully understood and psychiatric diagnosis itself is based on rather arbitrary criteria, **there is the possibility that the visuo-spatial disorder detected among such patients is of central importance in either the creation or the persistence of the psychopathologic state**. From an etiological perspective, the visuo-spatial management disorder in a number of these patients can be traced to early childhood. Thus it is reasonable to assume that all the subject's learning, from ordinary school work to modes of thought and interpersonal relationships, has been skewed because of such dysfunction and that the child has automatically assumed defective methods of adaptation to stress. Thus, **as life proceeds, it becomes increasingly difficult for him to make the necessary adjustments until some final stress triggers a major psychopathologic disturbance**. It is likely that the early disruption of the visual systems was itself the result of some stressful event. However, for a variety of reasons, the deficit, rather than correcting itself, endured.

In more immediate terms, **it is also reasonable to assume that contemporary stress forces some degree of visual-perceptual decompensation, which, in turn, makes it more difficult for the individual to successfully master stressful situations. Moreover, even if he has largely recovered from the effects of stress, the visual-perceptual deficit may persist, seriously delaying his ability to fully regain health**. The ability to perform academic or vocational tasks and to effectively socialize are important elements in the rehabilitation process. Visuo-spatial management dysfunction, however, interferes with these objectives and hampers the individual's efforts to recover, whether independently or as part of a rehabilitation program.

Career-Specific Sources of Stress

Perception is a self-selecting, self-directing action in search of information with sensory feedback. In evaluating the visual systems in our series of patients, we were able to detect **two general styles of perception: the central and the peripheral**. In simplest terms, **central vision is that called on for attention to form, such as close details; in its extreme form, it has been called "tunnel vision." Peripheral vision deals with the larger environment, scanning, if one will, the wide distances of space, in an extreme form seeing the whole at the expense of the minutiae. It has been postulated that visual-perceptual styles even reflect thought patterns**. The more obsessive pattern of thought, caught in particulars, is central; a more global, conceptual, and imaginative mode of thinking, at times to the point of being unable to limit or discipline the flow of ideas, is part of a peripheral style. **Ideally, although everyone has a predominant perceptual style, the visual system is sufficiently flexible so that one can, when required, shift smoothly and efficiently to the other perceptual style. In a large number of our patients, however, rigidity made such adjustments difficult; the patient readily locked into his dominant mode and found it exceedingly difficult to adapt to the demands of the alternative mode**.

In our original study reported in 1983, we ascertained the predominant visual style of each patient and compared this with the patient's occupational status. The styles of 27 of our subjects were essentially peripheral; 11 were central; 16 were peripheral with adequate central functioning; and 4 were primarily central with adequate peripheral functioning. We then selected the occupational status of each subject and divided these into groups depending on whether the kind of work demanded primarily a central or peripheral visual-perceptual style. The results of this analysis are shown in Table I.

TABLE I

Occupational Demands and Predominant Visual Styles

Occupation:	Peripheral	Central	Both
Central:			
Lawyer	2		
Accountant	2		
Veterinarian	1		
Dentist	1		
Artist	1		1
Editor	1	1	
Architect			1
Nurse		1	
Student	2	2	2
Office worker	2	4	2
Totals:	12	8	6
Peripheral:			
Sales, marketing	7	3	2
Unclassified:			
Housewife	4	1	1
Laborer	1		
Unemployed	3	1	1

It is at once apparent that 12 of the 24 patients with careers that, in large part, demanded the ability to effectively utilize central vision--e.g., accounting, dentistry, and office work--were primarily peripherally oriented and had serious restrictions on their ability to move centrally when the situation demanded. Of the 12 patients in general sales work (an occupation demanding a high degree of assertiveness and gregariousness), only three were restricted to a central mode of perception.

Several possibilities come to mind. **If a person is frozen in a mode of visual perception contrary to that required for much of his work, is it not likely that he will experience serious and increasing stress and distress in the process of accomplishing that work? If, during the course of a significant degree of emotional disruption, with the visual systems also decompensated to some degree, would not the particular perceptual mode, already restricted, only become more so, making it more difficult for the person to accomplish the tasks expected of him and adding to his already pronounced state of demoralization?**

A **case illustration** may clarify these points. A 32-year-old single woman consulted me because of persistent feelings of depression. Although she later described herself as having been depressed since late adolescence, it seemed most marked during the year before her first visit. She described difficulty falling asleep at night and episodic early-morning awakening, loss of sexual drive, **severe concentration impairment**, and an aversion to seeing friends or family. Her appetite was unaffected. Lacking self-confidence, **she was convinced she would lose her excellent position as assistant marketing director for a large magazine**.

Her state of depression seemed to have begun (or intensified) about one year before consultation, upon conclusion of an unsatisfactory love affair. For nearly eight years, she had been dating and eventually living with a divorced man ten years her senior whom she felt she loved, to whom she had become intensely attached, but who offered no commitment to marry and insisted that she tolerate his occasional flings with other women as part of his need to be free. Also, about the same time, she was promoted to her present position, having previously served her company in the field as a salesperson, a job she did well and found gratifying.

Her personal history revealed that **her mother and one of her siblings had suffered with depression**; her father had been killed in an automobile crash when she was six years old, and she held no memories of him. **Throughout her education, she was ambitious** and eager to succeed academically, but it was often a struggle for her to do well and to eventually carve out a significant career for herself.

During the first three months of individual psychotherapy--in the course of which her relationships with men, her attitudes toward work and career, and childhood and adolescence dynamics were explored--she showed some degree of clinical improvement. At the end of the first month of treatment, she was started on maprotiline (Ludiomil), 150 mg per day (a regimen she accepted with considerable reluctance because of her desire to recover "on her own." Clearly the antidepressant contributed to further relief of depression. However, **her concentration impairment and low self-esteem in her work persisted. She lived in fear that her procrastination and difficulty focusing on vocational tasks would cause her dismissal**.

Again, reluctantly, she accepted the recommendation (which had originally been made early on in treatment) to undergo **visual-perceptual analysis. Testing showed a Level II dysfunction in a peripherally organized individual**. She revealed not only vergence dysfunction and some degree of focusing insufficiency, but also spatial organization

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dysfunction, a perceptual loss of visual consistency resulting from the selective reduction of depth to a two-dimensional field.

In addition to assigned eye exercises to increase visual attention and vergence awareness that she was to carry out at home, she was given a special pair of prisms to wear at all times except while driving at night. The prisms were designed to initiate visual-perceptual change by compression and expansion of space and direction of viewed objects. Within several weeks, she noticed a significant reduction in the strain associated with her work and, over the next six months, a steady increase in work productivity. By the end of this time, it was no longer necessary for her to wear the prisms.

In this patient, the traditional psychiatric approach to the treatment of depression--combining psychotherapy with a heterocyclic antidepressant--was able to bring her only to a limited level of improvement. The addition of visual rehabilitation to her regimen seemed to contribute significantly to further reducing certain features of her disability, such as procrastination and concentration impairment, which had been previously considered a natural manifestation of her depression. Furthermore, the significance of her promotion, from field sales to assistant marketing director, as an additional contributant to her depression became comprehensible. Her peripheral perceptual mode had made it feasible for her to carry out the tasks associated with sales. However, when the amount of detail and paper work associated with her new position began to increase, she could not move "centrally" with enough freedom to accomplish this without considerable effort and distress. Frequently, especially since being depressed, she could not do her work at all.

Rehabilitation: Visual Training and Yoked Prisms

In our original series, of the 32 patients who revealed significant degrees of visual dysfunction (Level II selective reduction of depth to a two-dimensional field or Level III loss of the developmental interaction between visual and bodily spatial orientation), 30 complied with some form of visual rehabilitation. Treatment consisted of visual training, the use of special yoked prisms, or both. **When full training in the visual laboratory (supplemented by exercises at home with or without prisms) was used, the duration of treatment ranged from 3 to 12 months, with an average of 4 months. The course of treatment was influenced by the speed with which the patient's visual systems seemed to respond to the therapeutic regimen.**

Of the 16 patients with Level II dysfunction, 11 completed the program and showed a shift to Level I dysfunction. Of the 14 patients with Level III dysfunction, 9 continued in the program; 6 advanced to Level II dysfunction, 1 advanced to Level I dysfunction, and one remained unchanged. Patients who seemed to make the most significant progress visually also showed the most marked social and occupational gains during the course of treatment. However, since psychotherapy and sometimes pharmacotherapy were also utilized, it was impossible to know how much of the improvement could specifically be attributed to any single therapeutic modality.

The overall purpose of visual training is to create a change in the way the person perceives and integrates information that he receives. The objective is to influence the entire system rather than to follow the classical lines of correcting a single dimension of visual

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function, such as strengthening a so-called floating eye or simply enhancing visual acuity. In general, the more rapidly a person learns, the more quickly he seems able to make the desired perceptual readjustments.

The fastest way to initiate change in the perceptual systems is by placing a lens in front of the eyes. When one views the world through either a convex or a concave lens, perception is modified in both size and distance; a wedge prism changes direction as well. By compressing or expanding the observed visual field (depending on the particular patient's deficit and dominant mode of perception), changing the speed of organization, and controlling visual fields, one can exert a marked influence on the person's vergence malfunction.

Yolked prisms are essentially prisms of equal degree, with both bases placed in the same direction. Low magnitude prisms are used. For centrally organized people, the bases are placed down; for peripherally organized persons, the bases are placed up. The primary goal of this procedure is to introduce flexibility into the visual-perceptual system. Thus, the subject can adapt to changing stimuli and learn, step by step, how to see and understand what is before him.[6]

Case History:

A very dramatic case illustration involves a 24-year-old woman who had spent 10 years in and out of psychiatric hospitals, with recurrent episodes of depression and acutely disturbed behavior.[9] At the time of the initial visual evaluation she was in a state institution, unable to successfully attend school or do part-time work, markedly withdrawn from social contacts, and convinced of her incurability.

Interestingly, she had consistently responded poorly to phenothiazines and other antipsychotic agents, not unlike patients described in Bellak's research.[3] Psychological testing, however, revealed no convincing evidence of ADD.

On visual examination she described an inability to read. Moreover, when carefully questioned, she said that **visual images rarely lasted more than a minute and that she could maintain vision for longer periods only with great effort of will**. Asked when this problem had first begun, she recalled, at age four, an episode of looking out her bedroom window and seeing the trees and bushes moving in toward her, and being terrified by this event. A few hours before, she remembered having been very frightened at overhearing an argument between her parents in the adjacent room. (I have subsequently referred to her experience as the "Macbeth phenomenon," since it is so reminiscent of the famous scene in Shakespeare's play.)[FF] Since age 13, every attempt to engage her in studies had led to an intensification of her psychopathologic state, at times to the point of disorganizing panic.

On examination she revealed Level III spatial orientation dysfunction. Testing induced hysterical amblyopia, 20/200. Eye movement control was very erratic, and her accommodative-convergence function was severely impaired. Her predominant visual mode was central. **Although her visual systems were essentially free of organic pathology, this chronic schizophrenic patient was, for all practical purposes, functionally blind**.

Rehabilitation treatment consisted of rigorous visual training and the constant use of vertical yoked prisms. Over a six-month period, she moved from Level III dysfunction to Level II. **By the end of the first six** weeks of training, a marked improvement had occurred in her posture and dress. No longer did she walk in a slumped fashion, often peering at the floor as if she had to in order to see where she was located in space. By the end of the third month of training, she had obtained a license and began to drive a car. Six months later she had been discharged from hospital, was regularly employed, and no longer needed regular psychiatric care or any pharmacotherapy. Over the past seven years, she has created an independent life for herself and reveals no residual symptoms of schizophrenia.[10]

Conclusions

It would seem that there is a definite relationship between certain psychiatric disorders and visuo-spatial management dysfunction (a condition we have named the Kaplan-Flach syndrome), particularly among patients diagnosed as having schizophrenic disorders, recurrent unipolar depression, and alcoholism. Chronicity of illness (in excess of six months) and social withdrawal or occupational difficulties seem to be most marked among such patients.

Although the exact nature of the relationship between perceptual dysfunction and psychopathology remains unclear, the fact that the presence or absence of such dysfunction can be so easily determined should make us consider establishing visual-perceptual analysis as a routine procedure in the evaluation of all psychiatric patients. Moreover, by means of visual training and vertical yoked prisms, a regimen of visual rehabilitation can be carried out within the framework of learning theory so that the ability of these patients to function may often be substantially enhanced.

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QUESTIONS BASED ON THIS LESSON

13. In the authors' study, what percentage of psychiatric patients had significant impairment in visual-perceptual function?

A. 10%

B. 25%

C. 48%

D. 66%

14. Level I visual perceptual dysfunction is:

A. Considered present when convergence or divergence of eye movements is too large or small in reference to the object of regard

B. Called "spatial organization dysfunction"

C. Characterized by loss of visual constancy resulting from reduction of depth to a two-dimensional field

D. Characterized by an inability to track in pursuit while standing up

15. Perception may be defined as:

A. An alteration in visual or auditory function that accounts for hallucinations in certain patients

B. The dominance of visual over auditory systems

C. A self-selecting, self-directing action in search of information with sensory feedback

D. The internal basis of all thought processes

over, please...

16. In the study carried out by Drs. Flach and Kaplan, what percentage of those patients involved in work demanding adequate central vision appeared to be fixed in a dominant peripheral mode?

A. 15%

B. 30%

C. 50%

D. 90%

Directions in
Rehabilitation
Counseling

VOLUME 1 • LESSON 5

Cognitive Therapy for Depression

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EDITOR'S NOTE

Survey findings suggest 10-20% of the U.S. population will experience clinical depression warranting rehabilitative intervention. The significance of depression is exemplified by its relationship to marital/family disruption, suicide, substance abuse, as well as its impact within the workplace. While many psychotherapeutic approaches have been used in the rehabilitation process, cognitive therapy has received particular attention in recent years as one approach for treating depression.

Among the most prominent cognitive theories of depression in recent years have been: (1) Beck's negative self-schema and cognitive distortion theory; (2) Seligman's "learned helplessness" model; and (3) the "self-control" model synthesized by Rehm from previous suggestions of social learning theorists, including Kanfer and Bandura. Despite differences among these cognitive theories, each assumes that in most cases, the depressed individual's affective and motivational symptoms stem from distinctive types of faulty perceptions and cognition.

In this lesson, Drs. Jarrett and Rush present the cognitive model of depression with its three essential elements: the cognitive triad, silent assumptions, and logical errors (perhaps more accurately rephrased, errors of logic). The authors discuss establishing a therapeutic alliance, considered a critical first step in cognitive therapy. Specific techniques of self-monitoring, theme identification, and homework assignments are defined. As presented by the authors, the usual course of therapy consists of two individual sessions weekly for ten weeks.

While cognitive therapy has proven effective in treating non-psychotic, non-bipolar depressives, it remains unclear through what mechanisms or under what conditions this therapy produces its effects. Among questions yet to be addressed are: (1) when should the therapist combine cognitive therapy with antidepressant medications? (2) which clients are most likely to respond to this treatment? (3) what are the most effective modalities for delivering cognitive therapy?

Introduction

Cognitive therapy is a short-term psychosocial intervention designed to ameliorate the symptoms of nonpsychotic, nonbipolar depression (i.e., it is designed for symptom reduction) and to decrease the probability that depression will recur (i.e., it is designed for prophylaxis). This lesson describes briefly the cognitive model of depression, the typical course of cognitive therapy, and its evidence for effectiveness.

The Cognitive Model

The Premise of the Cognitive Model:

The premise of the cognitive model is that cognitions (images and thoughts) influence emotions and behaviors. This premise is grounded in a phenomenological approach to psychology, a perspective which assumes that **behavior is influenced by the individual's perception of himself and the world.** According to the cognitive model, the central feature of depression is distorted cognitions. Therefore, within the cognitive model, other symptoms typical of depression, e.g., motivational deficits, suicidal impulses, and sadness, are augmented by distorted thinking patterns.

Cognitive Therapy's Unit of Focus: Distorted Cognitions:

Rush[1] has defined cognitions as images and thoughts or "what a person thinks to himself in a situation." According to the cognitive model, cognitions are important because they are related to the feelings and behavior which occur in the situation. Beck[2] maintained that the **cognitions associated with depression are automatic, involuntary,**

plausible, persistent, and often contain a theme of loss. Beck distinguished between **socially accepted or objective definitions of particular events** (e.g., loss) **and private meanings of events** (i.e., the significance of the event to the individual). He stressed that **it is the private interpretation of events that is critical to the emotional responses that follow these events.** The emphasis on the private meanings of events reflects the roots of cognitive therapy in phenomenological conceptualization of psychopathology. However, it is also the disparity between private and public meanings of events which results in discrimination between "distorted" and "rational" cognitions (automatic thoughts).

In describing and theorizing about depression, Beck[3-5] identified **three elements deemed essential to the psychopathology of depression.** These are **the cognitive triad, silent assumptions, and logical errors.**

TABLE 1

Examples of Cognitions from the Automatic Thoughts Questionnaire*

I feel like I'm up against the world.
I'm no good.
Why can't I ever succeed?
No one understands me.
I've let people down.
I don't think I can go on.
I wish I were a better person.
I'm so weak.
My life's not going the way I want it to.
I'm so disappointed in myself.
Nothing feels good any more.
I can't stand this any more.
I can't get started.

*From Hollon SD, Kendall PC: Cognitive self-statements in depression: Development of an automatic thoughts questionnaire. *Cognitive Therapy Research* 4:383-395, 1980.

TABLE 2

Sample Items from Dysfunction Attitude Scale*

It is difficult to be happy unless one is good looking, intelligent, rich, and creative.

Happiness is more a matter of my attitude toward myself than the way other people feel about me.

People will probably think less of me if I make a mistake.

If I do not do well all the time, people will not respect me.

Taking even a small risk is foolish because the loss is likely to be a disaster.

It is possible to gain another person's respect without being especially talented at anything.

I cannot be happy unless most people I know admire me.

If a person asks for help, it is a sign of weakness.

*From Weissman AW: The Dysfunctional Attitude Scale: A validation study (Doctoral dissertation, University of Pennsylvania). *Dissertation Abstracts International* 40:1389-1390B, 1979.

Cognitive Triad:

The cognitive triad consists of the negative views held by depressives about themselves, their world, and their future (Table 1). Generally, the depressive assumes that he, his world, and his future lack some feature(s) that are a prerequisite for happiness. For example, the depressive may view himself as unworthy, inadequate, or incompetent. He may view his environment as continually demanding and unsupporting. He may describe the future as hopeless and predict that his deficits and current pain will continue indefinitely. These negative views, the cognitive triad, account for, maintain, or contribute to other symptoms commonly found in the depressive syndrome. That is, if the depressive thinks that "today will be just as miserable as yesterday," then he will feel and behave as if this thought were literally true or valid; for example, he will feel sad and stay in bed. These negative views are called automatic thoughts and they are found in the stream of consciousness of the depressive in specific situations.

Silent Assumptions:

The second element found in the psychopathology of depression consists of silent assumptions or rules. These are **unarticulated rules that influence the depressive's emotional, behavioral, and thinking patterns** (Table 2). Silent assumptions are psychological constructs and the client bases his emotional and behavioral responses on them. **For example, the depressive may believe, "If I am not loved by everyone, I'm unworthy." These stable beliefs develop from early experience and subsequently influence the individual's responses to events.** According to the cognitive model, these silent assumptions give rise to automatic thoughts. Silent assumptions are typically stated as "if-then" premises that can be identified by examining patterns within a group of automatic thoughts or behavioral responses.

Depressive assumptions are typically inferred by examining the situation, emotions, and themes associated with the array of negative automatic thoughts. For example, a depressed person may report sadness when her spouse does not compliment her on her appearance. She may report thinking, "He is not attracted to me anymore because I am ugly." She may also report feeling dysphoric when a friend talks to her for only five minutes in the grocery store. She may report thinking, "She would want to spend more time with me if I weren't so dull." Through repeated examples and verbal exchange, the therapist and client may infer the silent assumption, "If others don't attend to me, it's (a) something to be disturbed about and (b) because of a deficit I have."

The cognitive model posits that these inappropriate assumptions are activated more frequently than appropriate (undistorted) assumptions when a person is depressed. It is assumed that as the depression becomes more severe, the individual's thinking becomes more disparate despite logical or objective evidence to the contrary.

Logical Errors:

The third element essential to this cognitive model are the logical errors spawned by the negative automatic thoughts made by the depressive. Logical errors are identified by examining logical relationships between a specific event and the associated negative automatic thought. Some examples of logical errors include arbitrary inference, selective attention, overgeneralization, magnification or minimization, and personalization. Arbitrary inference occurs when the depressed person draws conclusions that are not supported by logical or environmental data. Selective attention refers to emphasizing certain details and ignoring others. Overgeneralization includes drawing conclusions about one's ability, performance, or worth based on a single incident. Magnification or minimization refers to exaggerating or diminishing, respectively, the importance of an event. Personalization involves associating events with oneself when logic or data would prohibit such associations.

The Vulnerability For and Maintenance of Depression:

According to Beck,[6] the existence of **silent assumptions increases an individual's vulnerability or predisposition to depression. These assumptions may develop through interactions with significant others.** In particular, **depressive assumptions are learned in the context of "an unfavorable life situation,"** e.g., the loss of a parent or chronic rejection by peers. **Later in life, when the individual is exposed to a situation analogous to the original unfavorable life situation, he or she employs the previously learned assumptions.**

Once activated, these schemata or assumptions are applied to an ever-widening array of stimulus situations and, thereby, lead to more negative automatic thinking. For example, a person who is overly concerned with approval from others may view normal day-to-day transactions as if they meant he or she is not liked by anyone, e.g., the stewardess on the airplane didn't smile. That means "no one likes me."

The typical emotional, motivational, behavioral, and vegetative depressive symptoms (e.g., hopelessness, apathy, agitation and sleep disturbance) are made worse by this negative automatic thinking. As depressive symptoms intensify, the distorted thinking increases. Beck has termed the relationship between depressive symptoms and thoughts a "vicious cycle," a "circular feed-back model," and the "downward spiral of depression."

The Typical Course of Cognitive Therapy

Establishing a Therapeutic Alliance and Rationale:

One of the first steps in cognitive therapy involves developing a **rapport with the client,** and **establishing a "collaborative alliance."**

The therapist's role in this alliance is to guide the client. For example, each session begins with the therapist and client listing and prioritizing items on the "agenda" to be covered. The competent cognitive therapist not only has refined general psychotherapeutic skills (i.e., he or she is perceived as warm, genuine, empathic, and able to understand and reflect the client's thinking), but also can remain objective and logical about the automatic thoughts and emotional responses identified. **The therapist usually phrases most comments as questions, rather than as statements, to be answered by the client.** The cognitive therapist typically **avoids attempting to "persuade"** the client that his or her thoughts are dysfunctional. Instead, the therapist **encourages the client to test the objectivity or validity of specific thoughts or ideas** by examining their inherent logic and/or by seeking supportive or discomfirming data within the client's daily life. Such an alliance has been labeled "collaborative empiricism."[7]

The therapeutic alliance is of special importance when working with depressives, who characteristically overpersonalize and are likely to respond negatively to neutral or even positive interpersonal interactions. When problems occur within the therapeutic context (e.g., relationship difficulties, missed appointments), these problems are conceptualized within the cognitive model. That is, corresponding thoughts and emotions are identified and problem-solving strategies are implemented. **For example, a depressive may report missing a therapy session after thinking, "I've been depressed before and received therapy. I'm depressed again so this won't work either." The therapist can consider the report of these thoughts as an opportunity to review the (a) similarities and dissimilarities of past and current therapies, (b) evi-**

dence supporting or refuting the notion that cognitive therapy will not work, (c) advantages and disadvantages of cognitive therapy to date, and (d) changes that may need to be made in the therapy.

To foster a collaborative alliance, **much time is devoted to providing a rationale for treatment.** The verbal rationale may be supplemented by asking the client to read a pamphlet entitled *Coping With Depression*.[6] This pamphlet aids in "socializing" the client to cognitive therapy by (a) describing many depressive symptoms from which the client may suffer, (b) illustrating dysfunctional thinking, (c) focusing on the relationship between dysfunctional thinking and depression, and (d) encouraging the client that his or her problems can be alleviated by learning to recognize negative thoughts, testing the validity of the thoughts, and problem solving.

Processes and Techniques of Cognitive Therapy

Self-Monitoring:

Self-monitoring is used to aid the client in identifying thoughts which accompany uncomfortable emotions and difficult situations. By completing the Daily Record of Dysfunctional Thoughts (Table 3) and through dialogue, the client begins to distinguish and to note the relationship between thoughts, events, emotions, and behaviors. For example, the client may note that (a) she feels sad (i.e., the emotion), (b) when a co-worker does not say, "Good Morning" (i.e., the situation), and (c) she thinks, "Nobody likes me here enough to say hello" (i.e., the automatic thought). After noticing the covariation between this situation, emotion, and thought, it is understandable that this client now avoids the office coffee break, i.e., she assumes nobody likes her.

TABLE 3
Daily Record of Dysfunctional Thoughts*

Date	**Situation** Describe: 1. Actual event leading up to unpleasant emotion, or 2. Stream of thoughts, daydream, or recollection, leading to unpleasant emotion.	**Emotion(s)** 1. Specify sad/anxious/angry, etc. 2. Rate degree of emotion, 1-100.	**Automatic Thought(s)** 1. Write automatic thought(s) that preceded emotion(s). 2. Rate belief in automatic thought(s), 0-100%.	**Rational Response** 1. Write rational response to automatic thought(s). 2. Rate belief in rational response, 0-100%.	**Outcome** 1. Rerate belief in automatic thought(s), 0-100%. 2. Specify and rate subsequent emotions, 0-100%.

Explanation: When you experience an unpleasant emotion, note the situation that seemed to stimulate the emotion. (If the emotion occurred while you were thinking, daydreaming, etc., please note this.) Then note the automatic thought associated with the emotion. Record the degree to which you believe this thought: 0% = not at all; 100% = completely. In rating degree of emotion: 1 = trace; 100 = the most intense possible.

*From Beck et al.: *Cognitive Therapy of Depression*, Guilford Press, New York, 1979.

After the client has learned self-monitoring, she is taught to **identify themes,** ideas which recur across situations, by reviewing past records and sessions (e.g., fearing rejection, seeking approval). By identifying and discussing these pervasive themes, the client and therapist infer the client's general rules or silent assumptions.

Evaluating the Validity of Cognitions:

Subsequently, **the client learns to determine the extent to which his or her cognitions** (i.e., automatic thoughts and silent assumptions) **correspond to an objective appraisal of the particular situation.**

When the thoughts or assumptions do not match the "evidence," **the client is taught to revise these cognitions** with more accurate ones and to carry out responses consistent with this modified view.

TABLE 4

Behavioral Techniques*

Activity Scheduling
Mastery and Pleasure Ratings
Graded Task Assignment
Cognitive Rehearsal
Assertive Training/Role Playing
Mood Graph

*From Rush AJ: Cognitive therapy of depression. Rationale, techniques, and efficacy. *Psychiatric Clin North Amer* 6:105-127, 1983.

TABLE 5

Cognitive Techniques*

Recording Automatic Thoughts (Cognitions)
Reattribution Techniques
Responding to Negative Cognitions
Counting Automatic Thoughts
Identifying Assumptions
Modifying Shoulds
Pro-Con Refutation of Assumptions
Homework to Test Old Assumptions
Homework to Test New Assumptions

*From Rush AJ: Cognitive therapy of depression. Rationale, techniques, and efficacy. *Psychiatric Clin North Amer* 6:105-127, 1983.

The general process of evaluating the validity of automatic thoughts or silent assumptions is accomplished through a variety of techniques (Tables 4 and 5). When evaluating the validity of cognitions, the first basic goal is to **teach the client to recognize that thoughts and beliefs are inferences about the world rather than facts. When the client can conceptualize thoughts as assumptions or hypotheses rather than as facts, he or she can develop some "distance" from the emotions accompanying the thoughts.** Hence, the client learns to scrutinize thoughts by asking questions such as: what part of my situation is a fact and what part is my belief; what evidence is there to support or to refute my thoughts; what are some alternative explanations for my thoughts; how would a nondepressed person view my situation; and even if my thoughts match the facts, is it truly as bad as it seems? Through this type of questioning, the client learns to recognize and to correct logical errors.

In addition to learning to evaluate thoughts logically, **the client learns to view these thoughts as hypotheses that can be tested.** The client learns to (a) state his cognition in a testable form (i.e., make a prediction), (b) arrange and implement a test of the prediction, (c) record results, (d) compare results to the prediction, and (e) query whether additional experiments are necessary to test the validity of the thought. For example, a depressed lawyer reported, "I'm so disorganized and distracted, I'll never complete my work." Such a prediction is especially suited to a common technique used in cognitive therapy called graded task assignment. Through graded task assignment, the client was taught to operationalize work, e.g., a legal report, and to break it down into small, specific, realistic tasks to be completed over time. Within the experiment, the lawyer predicted she could not complete the first step of gathering the related legal books and moving all other distracting materials from the desk. Such thoughts which might interfere with the task (e.g., "I'm too incompetent to complete the first step") were identified and the therapist emphasized partial successes. Each component of completing the legal report was specified, and accomplishing the tasks was viewed as an experiment. Throughout the experiment, the lawyer recorded her progress and compared these results to her initial prediction. At the end of the experiment, she concluded that she was, in fact, able to make some progress on her legal report and had made overly pessimistic predictions which interfered with her working effectively.

Homework:

One of the most important aspects of cognitive therapy is the "homework" assignment which is completed outside the therapeutic session. **Homework is tailored to address the automatic thoughts, silent assumptions, or particular symptom targets chosen by the client and therapist. Each session includes a review of the homework.** Noncompliance with homework assignments is dealt with using a cognitive model, as is any difficult behavior (e.g., what thoughts and emotions occurred when you had difficulty beginning the homework?).

Frequency, Length, and Modality of Treatment:

To date, there are few studies designed to determine what, if any, relationship exists between the frequency or length of treatment and response to cognitive therapy. One preliminary report suggests that moderately to severely depressed clients evidence fewer dropouts and greater reduction in symptoms when treated twice a week than when treated once a week.[7] **In research protocols, cognitive therapy typically occurs twice a week for ten weeks,** i.e., 20 sessions. Experienced cognitive therapists recommend that the frequency of sessions be determined by the severity of the depression; i.e., as severity increases, frequency increases.

No studies to date have examined the effect of maintenance or "booster" sessions on therapeutic response. In practice, it is common for clients to participate in booster sessions (once or twice a month) for six to twelve months after routine cognitive therapy.

The typical modality in which cognitive therapy occurs is individual sessions. Rush and Watkins[8] compared cognitive therapy, administered to an individual and a group modality, and found **an advantage for the individual modality.** Clinical experience suggests that cognitive therapy may also be used with couples, as well as with individuals.[9]

The Effectiveness of Cognitive Therapy

The outcome data from individual and group cognitive therapy, involving clinic patients, community volunteers, and college students, has been detailed elsewhere.[1] **A few studies compare the effects of cognitive therapy and other forms of psychotherapy.** For example, there is evidence suggesting that group cognitive therapy with clinic patients produced greater symptom reduction than a waiting list control, insight therapy,[10] nondirective treatment, or "behavioral" treatment.[11]

Much of the outcome data on cognitive therapy has included comparisons with antidepressant medications. To date, no study has demonstrated that the effects of antidepressant medication exceed those of cognitive therapy. Typical findings indicate that at the end of treatment the two methods produce equivalent effects[8,12] or that the effects of cognitive therapy exceed those of antidepressant medication.[13-15]

Presently, the question of whether greater symptom reduction or prophylaxis occurs when cognitive therapy and pharmacotherapy are combined cannot be definitively answered. Blackburn et al.[13] found that for psychiatric clinic outpatients a combination of cognitive therapy plus antidepressants reduced symptoms more than either cognitive therapy or antidepressants alone. Murphy et al.[12] found the effects of cognitive therapy alone equaled a combination of cognitive therapy plus drugs as well as a combination of placebo and cognitive therapy. In conclusion, it appears that **clients who receive cognitive therapy can be divided into two groups: those who show a good response to cognitive therapy alone and those who show a better response when cognitive therapy and antidepressant medication are combined.**

The prophylactic effect of cognitive therapy must be demonstrated in order for cognitive therapy to be recognized as a cost-effective treatment for depression. Although more investigation is necessary, the results of several studies suggest that cognitive therapy reduced the rate of relapse more than antidepressant medication.[16-18]

Predicting Response to Cognitive Therapy:

Only recently have researchers begun asking for which clients is cognitive therapy indicated or contraindicated. At present, there are no definitive predictors of response to cognitive therapy. Beck et al.[7] state that clients with hallucinations, delusions, organic brain syndrome, borderline personality disorder, and schizoaffective disorders may not respond to cognitive therapy or may not respond when cognitive therapy is conducted in its typical time-limited format. Failure in treating depression with cognitive therapy has been the subject of a recent review by

Rush and Shaw.[19] **Clinical experience suggests that responders typically show a 50 percent symptom reduction (e.g., as shown on the Beck Depression Inventory or Hamilton Rating Scale) by approximately the twelfth to fourteenth session, i.e., assuming sessions occur twice a week for five to seven weeks. Rush hypothesizes that endogenous depressions, which are associated with dexamethasone nonsuppression, may show a poor response to cognitive therapy.** He further suggests that biological tests (e.g., the dexamethasone suppression test and the EEG taken during sleep) may be useful in predicting response to cognitive therapy.[20]

Conclusion

Cognitive therapy is an effective approach for treating a subset of nonpsychotic, nonbipolar depressives. To date, the literature suggests that cognitive therapy both reduces depressive symptoms and decreases the probability of relapse in a subgroup who respond initially. **Theoretically, it is unclear through what mechanisms cognitive therapy produces its effects or to what extent the cognitive model accurately describes the development and maintenance of a depression.** Practical issues involving the conditions under which cognitive therapy is maximally effective are yet to be resolved. These questions include: when should the therapist combine cognitive therapy with antidepressant medication; what are the most effective and efficient modalities for delivering cognitive therapy; and which clients are most likely to respond to this treatment.

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QUESTIONS BASED ON THIS LESSON

17. Which of the following statements is/are correct?

A. Cognitions associated with depression are largely voluntary, intermittent, and rarely contain a theme of loss

B. The private, personal interpretation of events is more critical to the emotional responses that follow these events than the socially popular or acceptable norms of response

C. Depression is largely caused by the inordinately positive views of self, the world, and the future held by depressed clients

D. It has been proven impossible to alter clients' automatic reactions to stimuli if the basis for such reactions was established early in life

18. According to cognitive therapy theory:

A. Silent assumptions are unarticulated rules that influence emotional, behavioral, and thinking patterns in the direction of low self-esteem and depression

B. The cognitive triad consists of (a) biological, (b) environmental, and (c) psychological influences in depression

C. Logical errors indicate serious thought disorders similar to, but not identical with, those seen in schizophrenic clients

D. Antidepressant drugs are useless in treating depression

19. Which type of logical error is a client making when he draws conclusions, based on a single event or incident, about his ability, performance, or self-worth?

A. Arbitrary inference

B. Selective attention

C. Overgeneralization

D. Magnification or minimization

over, please...

20. Cognitive therapy:

A. Does not require rapport or a collaborative alliance between rehabilitation therapist and client

B. Involves actively questioning the client, a tactic designed to encourage him to test the objectivity or validity of specific thoughts or ideas

C. Follows a strategy of listening and interpretation

D. Avoids establishing or communicating a rationale for treatment

Directions in
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VOLUME 1 • LESSON 6

Listening Processes in Psychotherapy and Counseling

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EDITOR'S NOTE

Biased or defective listening may often impedes accurate client evaluation and treatment progress. While listening is a central activity in all psychotherapy, relatively little attention has been paid this important topic until recent advances in cognitive psychology. In this lesson, Dr. Watts explores current investigations into psychotherapeutic listening.

He begins by noting the properties of clients' speech and offers reasons why it may be difficult to grasp the meaning of what an individual client may be saying. A distinction is made between manifest content and latent content. He cautions that attending solely to one aspect of communication--e.g. latent, as opposed to manifest, content--sets the stage for missing important cues and inferring the presence of attitudes or feelings which may not be present. Dr. Watts further notes that the psychotherapist's expectations may cloud critical objectivity in listening.

Recognizing the signs of "important moments in therapy" is essential. Significant cues may include: voice quality, posture and movement, evaluative terms, topic sequence, slips of tongue, frequency of words/topics, novel metaphors, and unintelligibility.

The author concludes with a discussion of active vs. passive listening strategies, one of the fundamental issues of listening in psychotherapy. He notes that listening goes through two phases, each requiring a different approach. Whether the therapist engages in active or passive listening should depend upon the individual client and the phase of psychotherapy.

Introduction

How psychotherapists listen to their clients has attracted surprisingly little attention in the extensive literature on psychotherapy. Theodor Reik's *Listening with the Third Ear*[1] is still a classic, yet the time may now be ripe to progress with this important topic. **Major recent advances in cognitive psychology concerned with general processes involved in understanding language and acquiring knowledge[2] provide the framework for a formulation of listening skills of the psychotherapist.** A number of authors[3-5] have recently approached psychotherapeutic listening from this point of view. The cognitive processes involved in psychotherapeutic listening are very complex, and there has been very little direct investigation of these processes.

Clients' Language

Before considering how psychotherapists should listen to clients, it will be helpful to note the properties of clients' speech. Like most impromptu spoken language, it will frequently be unclear or ambiguous, but for several reasons there may be particular difficulties in understanding clients in psychotherapy.

First, **clients will try, at least sometimes, to express things that are at the boundaries of their conscious awareness and of which they have little previous experience articulating.**

Second, some clients will systematically **lack the concepts necessary to grasp the significance of important aspects of their experience.** Psychosomatic clients, for example, have been said to have poorly developed emotional concepts.

Third, the clients' motivations to communicate may be ambivalent. Important material may be embarrassing to disclose, and the clients' attitudes about disclosure may fluctuate depending on the state of their relationships with the therapist. Last, the material that eventually needs to be presented (the linking of current relationships and concerns, an autobiography from infancy onwards, and the therapeutic relationship) is extremely complex. Information hinted at can only be properly understood in light of other material. Sometimes this other necessary material will not have been presented at all. At other times the therapist will need to relate a single statement of the client to a great deal of scattered material that was previously revealed in order to make sense of the statement. This point is underscored in a masterly study of therapeutic disclosure,[6] in which one of the principal methods discussed was how a single remark of the client needed to be expanded to include extensive material from many other statements if its implicit meaning was to be fully explicated.

This emphasizes the difficulty of comprehending the psychotherapeutic client. The main factor to set against this is that the client normally has a basic need and wish to be understood. Partly because of this, and partly through involuntary processes, important material is likely to be repeated. Clients usually give their therapists more than one chance to grasp an important point.

Manifest and Latent Content

To what extent should a therapist accept at face value what the client says? Psychotherapists have often made a distinction between the manifest content of what the client says (i.e., its ostensible, surface meaning) and its latent content (i.e., the unconscious themes that can be discerned beneath the surface meaning). **How should therapists divide their attention between manifest and latent content?**

Manifest Content:

Attending accurately to manifest content is not as easy as many assume. Shapiro,[7] in an important paper on assessment interviewing, has provided an excellent exposition of the problems. **The most substantial body of relevant empirical information comes from studies of listening deficiencies in opinion survey interviews.** It confirms that **the expectations of interviewers determine what they think they have heard.** Particularly interesting are some of the factors that affect interviewers' errors in accurately recording responses. **Ambiguous statements present particular problems and are likely to be either omitted or distorted in the interviewers' accounts of what was said.** Another finding, which will surprise no psychotherapist, is that **behavior stressful to interviewers results in their making more listening errors.** However, it may also be salutory for psychotherapists to know that **errors are high among interviewers who are oriented toward creating a good interpersonal relationship rather than addressing the task in hand.**

We do not know how far such findings of inaccuracies in nonclinical interviews are paralleled by similar deficiencies in psychotherapists. How much the progress of psychotherapy is impeded if a therapist misunderstands what the client has said is an open question. However, the provisional conclusion must be that errors in listening to surface content are easy to make and are probably quite common.

Reading Between the Lines:

It is not sufficient in psychotherapy simply to attend to the manifest content of what clients say. This follows from the assumption that material that is central to the client's problem and that is associated with particular anxiety is unlikely to be produced easily. So, if the therapist is not to miss issues that are really important to a client, he will need to learn to "read between the lines" of what is actually said.

Spence[5] has provided some very elegant evidence that illustrates one way in which the clients' underlying concerns may be revealed under camouflage. **In studying the words used by clients suspected of cancer, he found that the word "death" was commonly heard among clients whose diagnosis of cancer was subsequently confirmed.** Many uses of the word occurred in contexts that had no obvious connection with illness (e.g., "I was tickled to death"), and such usages would have been missed by a therapist attending only to manifest content. **Spence coined the term "lexical leakage" to describe this phenomenon.** We do not know how common it is, but it is only one of many ways in which unconscious concerns emerge in camouflaged ways in clients' speech.

Risks in Listening Strategies:

Before looking in further detail at other ways in which latent material can manifest itself, and the strategies psychotherapists can use in listening for it, we must consider the different kinds of risks associated with attending to manifest and latent content. Exclusive attention to manifest content may result in the therapist's missing

important material. On the other hand, an overeager search for latent content carries with it an opposite risk: the therapist may think he has identified important unconscious themes that are not actually present.[9] The possibility of such an error occurring, and the difficulty of checking for it, seem to have been seriously underestimated by psychotherapists.

For example, **a therapist may pick up a range of cues that could indicate hostility. Sometimes the cues discerned will really represent hostility, other times they will not.** It is rather like listening to a poor quality radio and trying to distinguish between real signals and background noise. This analogy with signal detection, which has been extensively used in psychology, will help us here. **Two very different factors can result in a listener picking up genuine signals of hostility more often. One is a real improvement in acuity, i.e., in his capacity to distinguish between genuine hostility and misleading "noise" that does not indicate hostility. The other possible factor is simply that the listener has lowered the criterion for what he accepts as a signal of hostility.** He may simply have decided to accept almost anything as a signal of hostility. **This would result in his picking up more correct signals of hostility, but at the cost of more "false alarms," too**--cases in which he thinks he has detected hostility, but is actually mistaken.

There is some disturbing, albeit inconclusive, evidence[9] that as psychotherapists improve their ability to detect signals of hidden themes, such as hostility, the improvement might be done partly by lowering their criterion for what they accept as a signal rather than by improving their ability to distinguish true signals from background noise. This problem arises because **psychotherapists, rehabilitation practitioners included,**

tend to base confidence in their judgment on the number of times they are right and take little notice of the number of times they are wrong. In the example of hostility, therapists' confidence may be inflated by the increasing number of times they correctly recognize hostility, but may not be correspondingly deflated by the number of mistakes they make.

Listening for Latent Content:

Most psychotherapists develop rules, often only implicit, to help them listen for important concerns of clients that may be only latent. Such rules fall into two main groups. **Some simply alert the therapist to moments in therapy when important material may be close to the surface. Others can be used as a more direct guide to the clients' assumptions and preoccupations.** The next two sections contain an illustrative list of such implicit rules, largely drawn from papers by Peterfreund,[4] Rice,[10] and Watts.[5] It should be noted, however, that in **many cases we have no scientific evidence to indicate whether or not these are good rules for psychotherapists to use.**

Important Moments in Therapy

Several cues can alert therapists that the client may be touching on something of particular importance. They are not infallible, but they indicate moments when the therapist should listen with unusual care.

Voice Quality:

The tone of voice that clients use is one of the best indicators of how emotionally involved they are at any particular point in a ther-

apy session. Rice and Wagstaff[11] have reported important research findings on voice quality as an indication of productive periods in a psychotherapy session. Rice[10] describes the kind of "focused" voice involved, as follows:

> There is a kind of voice quality that seems to indicate an inner focus on something that is being seen or felt freshly. Sometimes in the midst of a long client discussion expressed in a highly externalizing voice quality one hears just a small blip of focused voice. The voice slows, softens without losing energy, pauses, and loses the "premonitored" quality of the externalizing voice. This should be an indicator to the therapist that this part must be heard and responded to.

Movement and Posture:

Related aspects of posture and movement can help alert the therapist to important material, including shifts in body posture, sudden changes in direction of gaze, and signs of increased physical tension.

Moments of Unintelligibility:

The therapist should **be alert for times when the client says something that the therapist does not understand.** This may be a cue that the client is struggling to articulate something of emotional significance that is difficult to grasp consciously. The same cue applies when the client's affect is not appropriate to what he says.

Sequence:

Just as the therapist should attend carefully to things he does not understand, so he should **note carefully abrupt changes of topic in which no logical connection exists.**

Slips of the Tongue:

Freud's classic monograph on the psychopathology of everyday life[12] drew attention to the significance of slips of tongue. They help to alert the therapist to topics that may be emotionally important. Peterfreund[4] gives an example of a client who had had a vasectomy speaking first of being "still sterile," then correcting it to "again sterile," when he actually meant "now sterile."

Novel Metaphors:

Important moments in therapy are associated with the client's use of novel or unusual metaphors. Pollio et al.[13] have provided convincing evidence that moments of insight are associated with the use of novel metaphors, though trite or "frozen" metaphors are hardly ever used at such moments. Rice[10] has drawn attention, for example, to the unusual use of sensory words such as a client speaking of a "stretched" smile on the face.

Assumptions and Preoccupations

Some of these listening rules also help therapists grasp important themes in clients' material. The sequence in which topics are raised can be an important clue to their significance. Slips of tongue may reveal unconscious thoughts. Novel metaphors, besides alerting the client to important moments in therapy, can reveal ideosyncratic concepts that may be important in understanding the clients' experience and psychopathology. There are other aspects of the clients' language that reveal such concepts.

Conjunctions of Adjectives:

The conjunctions that link the adjectives used in describing an important person are often revealing. Listen, for example, to whether a client talks about people being "strong and loving" or "gentle and loving" and one can see what assumption he makes about how these qualities are related. Kelly[14] has convincingly argued for the importance of such "personal constructs" in explaining personal development.

Evaluative Terms:

Evaluations–favorable or unfavorable–expressed by a client often reveal important assumptions and personal needs also. **Expressions of criticism are often richer in content than are expressions of approval.**

Frequency of Topics:

Topics that the client uses frequently are likely to be important too. Therapists, therefore, listen carefully to the frequency with which a topic comes up, as well as what is said. For example, if a client frequently raises the topic of hostility, but denies that it is a problem, the therapist would begin to suspect otherwise.

Frequency of Words:

In addition to topics, **the therapist will attend to what words are used with unusual frequency.** The previously described research on lexical leakage by Spence[3] makes the point that important concerns can manifest themselves in frequent use of a word such as "death."

Listening for Particular Content Categories:

Areas of content that are particularly important probably vary from one kind of presenting problem to another, and from one stage of therapy to another. The therapist may, therefore, adopt a strategy of attending very closely to material of a certain kind. **In 1983 Hedges[15] published a survey of four therapeutic approaches in terms of the listening focus on which they are based. The listening perspectives she considers correspond roughly to the psychotic, borderline, narcissistic, and neurotic categories of clients.** The experienced therapist develops an ability to focus on material that is believed to be relevant to a particular kind of psychological problem.

Active vs. Passive Listening Strategies

What is perhaps the most fundamental issue about listening in psychotherapy has been left until last: **Should the therapist be active in listening selectively for certain kinds of material and relate it to his emerging formulation of the client or should he simply maintain what Freud called "evenly-suspended" or "free-floating" attention.**

Working Models:

Peterfreund[4] has provided a statement of the active approach to psychotherapeutic listening, centered around the concept of a "working model." **Working models encapsulate information that has been acquired about a particular topic, shape our perceptions by sensitizing us to some events rather than others and giving form and structure to our perceptions, and guide our responses, making possible prediction, action, and other adaptive functions. Working models are** continually updated as new information becomes available. Such a concept is an accepted feature of contemporary cognitive psychology,[2] though it goes under a variety of names ("schema" being one of the most common) and is defined in a variety of ways. However, there is general agreement that an important aspect of the comprehension of linguistic material is its relationship to internal cognitive structures such as "working models."

With this in mind, Peterfreund proposes that the analyst develop a series of working models to underpin his professional work, one of these being the model of the individual client (though this would be based in part on more general models of the development of psychopathology, etc.). Once a model of a client has begun to develop, it can be used to structure the listening process. One simple use is to distinguish old material that has already been incorporated into the model from new material that may require a revision of the model. Information will also be categorized according to its relevance to the model, and irrelevant information is ignored. In general, material that is consistent with internal models is better remembered than incongruent information, though there may be exceptions to this rule.[5] This is worrisome because it may result in the therapist's clinging to a prematurely formulated model of the client's pathology when an open-minded and unselective evaluation of the material available would lead to its being rejected or radically modified. Finally, material tends to be distorted so that it better agrees with the model. This is probably what accounts for many mistakes that were noted in the discussion of listening to manifest content. All these consequences of working models, or schemata, for the perception and comprehension of linguistic material have been well established as general principles.[2] So far there has been no satisfactory empirical investigation of whether they apply to listening processes in psychotherapy, though it seems reasonable to assume that they do.

"Evenly-suspended" Attention:

It is an interesting fact that Freud anticipated many of these issues, even though they had not yet been demonstrated by modern scientific methods, and he discussed their consequences for psychotherapy. In the series of lectures known as "Recommendations to Physicians Practising Psychoanalysis,"[16] he said:

> **For as soon as anyone deliberately concentrates his attention to a certain degree, he begins to select from the material before him...and in making this selection he will be following his expectations or inclinations....In making the selection, if he follows his expectations he is in danger of never finding anything but what he already knows; and if he follows his inclinations he will certainly falsify what he may perceive.**

Equally interesting is Freud's solution to this problem, which is that the therapist should adopt a style of "evenly-suspended" or "free-floating" attention, which "consists simply in not directing one's notice to anything in particular and maintaining the same 'evenly suspended attention' (as I have called it) in the face of all that one hears."[16] He adds that "...this rule of giving equal notice to everything is the necessary counterpart to the demand made on the client that he should communicate everything that occurs to him without criticism or selection."

This concept of evenly-suspended attention has been discussed at length by Reik.[1] The contemporary psychoanalytic theorist, Bion,[17] has developed a similar concept of attention "without memory or desire."

It can be seen that there may be a number of advantages in this strategy. One that Freud does not explicitly mention is that **it might be helpful in reducing the impossible cognitive burden that would fall on a therapist who tried, in an open-minded way, to consider all possible formulations of the material available to him** and the implications of everything the client said. **Attempts to do this consciously and rationally would simply break down, because the amount of information processing required could quickly exceed capacity. Freud's concept of evenly-suspended attention probably involves processing much material "pre-consciously" rather than consciously,** thus bypassing the point (i.e., consciousness) at which constraints on processing capacity are most severe.

However, it is questionable whether adopting this kind of rather passive, unselective processing strategy in fact reduces selections and distortions due to "expectations" and "inclinations." While it may, **it is also possible that evenly-suspended attention would increase the amount of distortion of material that took place.** It may do nothing to prevent distortion to accord with the therapist's working model of the client, but instead could simply reduce the level of conscious vigilance against such distortion.

Finally, **it is doubtful whether it is realistic for a psychotherapist to follow Freud's advice, or indeed whether Freud himself did so. Evenly-suspended attention would make it very difficult for the therapist to develop a coherent formulation of the client's psychopathology or even to remember the material, because memory is largely dependent on contact between incoming material and mental "working models."** Later in the same lecture to physicians, Freud acknowledges the difficulty a psychotherapist encounters when recalling at will a client's material. However, he argues that the material that arises serves to aid recall of related material revealed previously, a process now known as "cued" recall.

Two Stages:

Freud's declared strategy of evenly-suspended attention does not carry conviction if taken to extremes or used as a sole listening strategy, though most would agree that **it has a place alongside a more active approach to listening. The relative importance of the two concepts may depend in part on the stage of therapy,** and many would accept the suggestion (made, for example, by Langs[16]) that **psychotherapeutic listening goes through two phases. In the first phase, evenly-suspended attention has its place, and the psychotherapist needs to be unguarded in his receptiveness to primary processes and to make full use of his unconscious sensitivities. However, this approach needs to be superseded by a second phase that, while retaining a degree of unguardedness, relies fundamentally on cognitive efforts at organization and formulation.**

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QUESTIONS BASED ON THIS LESSON

21. Which of the following statements is ***false***?

A. Listening errors appear to increase when a client's communication and behavior prove stressful to the therapist

B. Listeners who are very concerned with establishing good interpersonal relationships appear to make very few errors in listening

C. Listeners more concerned with addressing tasks at hand appear to make fewer errors in listening than listeners who focus on developing good interpersonal relationships

D. "Lexical leakage" describes how a client reveals his concerns by the particular choice of words he frequently uses, e.g., "death"

22. Which of the following statements is correct?

A. The therapist should have rigid, unchanging working models regarding each client

B. A flexible, psychodynamic model, uniquely suited to each client, should evolve in the course of listening

C. A tightly defined therapeutic model prevents therapists from distorting material communicated by their clients

D. Active listening is always preferable to passive listening

23. Passive, unselective listening in psychotherapy:

A. Was rejected by Freud as an inadequate approach to psychotherapy

B. Always reduces or eliminates biases in listening

C. Is usually more appropriately employed in the earlier stages of psychotherapy

D. Differs from active listening in that, during active listening, the therapist is expected to disclose a great deal about his or her own personal life and experience

over, please...

24. Which of the following statements about listening processes in psychotherapy is correct?

A. In over-eager searching for latent content, the therapist risks imparting themes and feelings to clients that are not actually present

B. Clinical experience does not help therapists sharpen their acuity in distinguishing genuine latent emotions from misleading cues

C. Most psychotherapists, like most listeners, are more inclined to notice the number of times their efforts are wrong than the number of times they are right

D. Maintaining a tightly held theoretical structure within which to interpret the latent content of clients' communications enhances the objectivity of the listener

Directions in
Rehabilitation
Counseling

VOLUME 1 • LESSON 7

Diagnosis and Management of Substance Abuse

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EDITOR'S NOTE

Substance abuse has become increasingly prevalent, crossing all age, socioeconomic, and vocational boundaries. The disorder is especially salient for rehabilitation counselors and psychologists, as substance abuse may present as a primary disorder or as a complicating factor among clients with physical or mental disabilities who may have ready access to multiple prescription drugs. Substance abuse, in turn, significantly impacts vocational stability and is frequently addressed by corporate Employee Assistance Programs. Every rehabilitation practitioner must, therefore, be alert to the presence of substance abuse and prepared to gather comprehensive evaluative information.

In this lesson, the author outlines the essentials of an effective history for substance abuse. One should determine the age of onset, as the earlier in life abuse began and the longer its duration, the more complications one may expect. Define the settings in which substance abuse is most likely to occur for each individual, e.g. alone, with others, or in the context of marital difficulties. In assessing the risk of withdrawal, carefully evaluate recent rates of substance use. Ask specific questions about specific substances, from alcohol and nicotine to cocaine and opioids.

Pay particular attention to the relationship between psychopathological symptoms and drug abuse. Inquire about the possible development of drug tolerance; to what degree the client is preoccupied with use of a specific drug; whether he or she feels or manifests loss of control with drug use; whether he or she has made efforts to decrease or stop drug use. Discover what "benefits" the client believes are derived from drug usage and what the motives are for currently seeking help.

The nature, extent, and limitations of confidentiality should be explored and appropriate reassurance offered.

In coordinating a multi-disciplinary treatment plan, the rehabilitation practitioner must consider substance abuse as a distinct problem. Concurrent medical and psychiatric disorders should be treated appropriately. Monitoring the client for drug use during treatment is important. Change is essential to cure, and whenever possible the client's family should be involved in the substance abuse rehabilitation program.

Each client must fully commit to treatment goals and recognize that the program will be long-term. Moreover, the client must have confidence that the professional team and community programs will be available to assist in the rehabilitative process.

Introduction

All rehabilitation practitioners should know how to recognize and treat primarily or to refer effectively any client with a substance abuse disorder. In view of the frequency with which these disorders present in ordinary clinical life, the competence to diagnose and treat substance abuse needs to be exercised on a routine basis. A substance abuse history should be as much a part of information-gathering as inquiries about allergies to penicillin are in internal medicine or symptoms of depression and anxiety are in a psychiatric workup. Unfortunately, it is the exception rather than the rule that clinicians seek competent substance abuse histories. In this lesson, information will be presented that will enable the rehabilitation practitioner to compile a competent substance abuse history and to refer appropriately and/or treat primarily.

The Substance Abuse History

In my view, **the essence of drug dependence, or drug abuse, lies in the relationship between the person and the drug.** Physical dependence is of secondary importance to this basic psychological relationship, although it may, when present in severe degree, come to determine some of the variance. Listed below are what I regard as **a set of questions that, when answered, should provide a profile of the relationship and thereby indicate what elements are necessary for treatment planning.** Following each point, I have a suggested specific question.

1. Age of first use. **How old were you when you first used (specify intoxicant)?** The answer to this question will give some indication about the prognosis and severity of the problem. In general, the

higher the lifetime dose the more problems one can expect. Clinical experience also suggests that those starting to use intoxicants such as alcohol and marijuana at age 10 will have more problems than those whose first use was at age 15. There is some rough prognostic utility to this measure.

2. Pattern of heaviest life time use. **When did you use (specify intoxicant) most heavily in your life?** Frequently this will tell you what clients have been doing with the drug. **For example, some clients only use drugs heavily enough to become dependent in the context of a marital or sexual relationship. Others will only use heavily when enmeshed in peer relationships.** For example, a high school senior may use heavily in the summer between high school and college while a member of a heavily drug-using peer subculture.

3. The recent pattern of use. **In the last two to three weeks, on the average, how many times a day did you use (specify intoxicant)? In this time what was the average dose in terms of dollars per day, milligrams, grams, etc.?** It is very important for clinical decision making to **know the dose and frequency of administration** of the drug for the period of two to three weeks immediately preceding the interview. **If there has been no use of an intoxicant for two to three weeks, it is unlikely that serious withdrawal sequelae have to be considered clinically.** Conversely, if intoxicants have been used heavily in this period, it is likely that at least some degree of physical and/or psychological dependence will be present.

4. What drugs should be queried. Clinical experience suggests that **asking about specific drugs yields the best histories.** In some cases--the arylcyclohexylamines, for example--the user is probably get-

ting a family of these drugs and not just the one PCP that users believe they are getting. PCP is made in "street" laboratories, often by chemists who are not well trained. What they produce is, therefore, frequently not pure. The following substances are the most frequently abused.

(1) **Alcohol**: It is important to remember that alcohol makes alcoholics. **The notion that the use of beer or wine precludes alcoholism, alcohol dependence, or alcohol withdrawal is untenable.** Therefore, it is important to inquire about use of alcohol in any form.

(2) **Nicotine**, in such forms as cigarettes, pipes, cigars: The Surgeon General's office has conducted research that suggests many clients in the United States want help in overcoming their nicotine dependence and will use information that is simply displayed on a physician's office coffee table. It is important to inquire routinely and to advise clients to seek treatment for nicotine dependence in addition to treating or referring for other drug problems.

(3) **Cannabis**: It is important to remember that **there are two forms of cannabis; one being marijuana or "pot"** and the other **hashish. The difference between these two forms is one of dose,** "pot" being between 2 to 10 mg. of THC per unit (a "joint") of use and "hashish" perhaps two to three times that amount.

(4) **Central nervous system depressants**, such as the barbiturates, benzodiazepines, methaqualone, glutethamide, and methaprylon. The slang term for this class of drugs is "downers".

(5) **Stimulants**, including amphetamines, cocaine and sympathomimetics, as might be used in diet preparations. The mechanism of action of these drugs is very similar. Under blind conditions, for example,

drug-sophisticated subjects could not discriminate amphetamines from cocaine. The slang term for this class is "uppers."

(6) **Tranquilizers, antidepressants, and over the counter (OTC) drugs: The sedative properties of these drugs define their abuse potential. These drugs are usually not used as primary drugs of abuse. Rather, they are used to enhance the intoxicating effects of primary drugs of abuse,** as "boosting the high" from heroin by using amitryptiline.

(7) **Inhalants**, such as glue, paint, aryl and butyl nitrates, nitrous oxide, gasoline, and industrial solvents: All these drugs can be abused by clients seeking intoxication. **In general, inhalants are used by very young populations, usually around the age of 12. As users mature they tend to give up inhalants. It is unusual to encounter a person abusing inhalants for more than a few years. If one does encounter such a case, the probability of neurological, renal, or cortical damage is very high and should be routinely tested.**

(8) **Arylcyclohexylamines**: These are phencyclidine (PCP) and its chemical relatives. Slang terms are "angel dust," "zoom," and "Sherman."

(9) **Opioids**: Heroin, morphine, methadone, meperidine, codeine, and their synthetic or natural derivatives have narcotic effects in human beings. They have many slang terms such as "horse," and "boy" for heroin.

(10) **Hallucinogens**: LSD, STP, and mescaline are some of the substances in this group.

5. Psychiatric symptoms and drugs. **The next important point for clinical inquiry is the relationship between psychiatric symptoms**

and drug use. For example, has a client experienced hallucinations or delusions only in association with use of hallucinogenic drugs or have hallucinations and delusions antedated the use of drugs? It is important to know whether the person has a primary substance abuse disorder or a primary psychiatric disorder complicated by a substance abuse disorder. Did he or she ever become paranoid, see or hear things that were not really there, without drugs being involved?

6. Tolerance and/or withdrawal. **The hallmark of withdrawal symptoms is tremulousness. One should question whether a client has increased the dose to achieve any desirable effect;** that is, has the client become tolerant? **Young alcoholics may show a "telescoping" of tolerance; i.e., they become tolerant and dependent in a matter of months instead of taking years as is usually the case in their adult counterparts.** Has it taken more of the drug to get "high" or to relieve withdrawal sickness?

7. Preoccupation with the drug. **Drug-dependent persons regularly report that drug taking and/or drug seeking occupies a major portion of their mental energies, and it does so to the exclusion of family and work.** Usually clients recognize this preoccupation. Has the client noticed that drugs are important enough to put family and work out of his or her mind?

8. Loss of control. Drug-dependent persons usually report that **their control over drug-taking is inconstant or nonexistent.** They may use drugs more often than they intend; they may use more than they intend; or they may report both processes. Has the individual become aware of his or her poor control over drugs regarding frequency of use or amount of use?

9. Using despite negative consequences. Drug-dependent persons also regularly report that they are **conscious of using intoxicants despite known disadvantages,** such as family disagreements, loss of mental function, blackouts, cirrhosis of the liver, the subacute bacterial endocarditis seen in heroin addicts, or perhaps financial drain from expensive habits. Has the client noticed that he or she uses it while aware that it is wrong for financial, personal, or health costs?

10. Attempts to cut down or stop. **Most drug-dependent persons report frequent attempts to stop or cut down because they realize there are negative consequences.** Has the individual tried to stop or cut down because he or she knows it is detrimental?

11. Is there a history of convulsions? **A history of adult onset of convulsions should raise the possibility of substance abuse.** In addition, if dependence on alcohol or depressants is present, a history of convulsions should lead the physician to recommend hospitalization, all other factors being equal. Has the subject ever had fits, convulsions, "falling out," or seizures?

12. What do they get from the drug? **It is sometimes important to point out to clients that, based on their own reports, they have no pleasure and frequently have great displeasure and substantial real life problems from their involvement with drugs.** It may be intuitive that people take drugs regularly because they get pleasure, but clinical experience, corroborated by a growing body of research, suggests that **people taking potent amounts of psychoactive substances on a regular basis induce a basic state of dysphoria which is temporarily relieved by the administration of the drug.** Often, when reviewing with clients what they get from the drug, the dynamics of their relationship

with the substance will become clearer, hopefully, not only to the clinician but also to the client. What are some of the feelings experienced when drinking, snorting, or shooting the drug?

13. Why are they coming for treatment at the present time? **Frequently drug abusers come to treatment because they have "bottomed out".** This can be loosely translated as **a major life crisis** precipitated sometimes by the decision of a spouse not to tolerate further drug taking; sometimes by occupational problems, as when the client's job is threatened; sometimes by legal pressures, as some forms of intoxicant use are illegal and occasion contact with the criminal justice system; or substantial health problems. What has happened to make the individual seek treatment now?

14. The confidentiality issue. It is important to remember that **opioids have unique legal requirements regarding confidentiality because there are stringent federal and state laws concerning who may or may not have access to the information an opioid abuser may divulge.** In general, **the client should be made aware that the clinician will not convey information divulged in the clinical encounter without written specific consent from the client. This will cover almost all probable occasions except those regarding medical emergencies, federal audits if the client's treatment is federally funded, and court orders that a clinician must follow. In some instances it may be necessary to consult a lawyer to ensure clinical decisions regarding release of information will not lead to a lawsuit.** A clinician might say, "You should know that without your written consent, I might be fined and/or jailed if I tell anybody--your wife/husband, employer, or children--anything about you, including confirming that I've ever seen you. If a

court tells me I must, then I will have to seek counsel about whether or not I can tell the court. If there is a medical emergency, I might have to tell. If your treatment is funded by federal money, auditors may have access to your records. Any questions?"

15. Vocabulary--a non-issue. The next clinically relevant point is one of vocabulary. Many health care professionals feel inadequate in responding to the needs of substance abusers because they do not know the slang of the drug world or perhaps the accompanying street slang. Clinical experience indicates that **drug abusers are seeking competent, concerned care; a lack of knowledge of street slang is, in most instances, a non-issue. If words are used that the clinician does not know, the clinician should simply ask what the terms mean.** For example, in Chicago there are drug patterns called "T's and Blues," "Doors and Fours," and "Syrup and Beans." One cannot keep up with all these even if one is a full-time specialist in drug abuse. I have never seen a client bothered because a clinician did not know the name of a particular drug, drug combination, or know street slang. The basic issue is concern and competence; the knowledge or lack of knowledge of street slang or of terms for drug abuse is irrelevant. The clinician might say, "I don't know what 'T's and Blues' are. What drugs are they?"

16. Get to the point. "Your mother and father say you are using marijuana. They are quite concerned. How do you see it?" "Your husband says you are taking 20 to 30 valiums a day. What is happening?" "How many drinks a day have you been having?" The classical wisdom in clinical practice is that drug abusers may deny or exaggerate their intake and that alcoholics will deny intake. This appears to be a stereotype. **The presence of denial or exaggeration seems critically related**

to the client's perception of the potential role of the person taking the history. Clinical experience with substance abusers, confirmed by research, suggests that **if clients see the clinician as a helper--not their spouse, company, employer, or military unit--they will usually give valid, reliable histories.**

17. Crisis aspect of coming to treatment. Finally, it is important to stress that drug abusers frequently are in crisis when they seek help. Thus, the first encounter with a substance abuser may have special significance because of this crisis aspect. What the clinician is trying to do is **reverse the sense of demoralization** being experienced by many substance abusers. Therefore, it is extremely important to **project an image of competence, confidence, and calmness.** What is relevant is a knowledge of referral resources, information sufficient for a sound clinical decision, and implementation of the decision.

Diagnosis

DSM-III diagnosis of Substance Abuse Disorders requires a review of three categories: (A) pattern of pathologic use, (B) impairment, and (C) a time dimension. This division into three elements is reasonable, but the division is also somewhat arbitrary. **Third-party payments, in addition to other considerations, dictate that the clinician diagnose in DSM-III terms.** The points in the history reviewed above should permit a DSM-III diagnosis without difficulty. Since the Substance Abuse Disorders is a relatively new classification, historically speaking, it should not be surprising if the categories are changed in subsequent editions.

The Treatment Plan

The following points should be considered when compiling a treatment plan for the substance abuser:

1. **Substance abuse disorders are independent problems.** From a pragmatic point of view, the clinician should adopt the position that opioid dependence or alcohol dependence are unique and independent disorders. They are not simply expressions of neurotic conflicts or social pathology, although they may be worse when aggravated by neurotic conflicts or social pathology. This is a very important point. Frequently, many clients will defend themselves by stating that they cannot stop taking chemicals until their neurosis or their marital problems are resolved. **The clinician should insist that the objective of treatment is immediate and complete cessation of the use of chemicals for intoxication.** Furthermore, the clinician should convey to the client that substance abuse is an independent disorder, one that needs treatment in its own right.

2. **The necessity of a program. Substance abuse disorders require a program that consists of a set of elements, many of which are not present in an ordinary psychotherapy relationship and/or a medical treatment.** Rehabilitation practitioners cannot treat substance abuse disorders solely with office psychotherapy.

3. **The program needs to be long term.** There is evidence that **when people become abstinent, changes persist in their bodies for many months, if not years.** The biology of these disorders, combined with the fact that **clients mourn the relationship they have developed with the drug,** dictate that the program be thought of in terms of many months and perhaps years. Most observers of substance abusers

believe the drug relationship takes on many of the characteristics of a human object relationship. Mourning, particularly since the relationship is psychopathologic, takes a long time and will not be accomplished in a three-week withdrawal program.

4. **The key to the program is change. Hopefully, the history will have exposed the dynamic of the client's relationship with the intoxicant, and the path of action will be clear.** For example, a spouse wanting to become abstinent but in a marriage where the other spouse is constantly using intoxicants and will not stop using may require separation or divorce. Immersion in a drug-using subculture means the client must become free of this social network if there is to be any chance of sustained sobriety. A change of residence or job may be in order. The requirement for change is real and usually the required changes are major.

5. **The treatment program requires monitoring. The use of breath analyzers and urinalysis tests for the presence of illicit drugs is a very important element in a modern substance abuse treatment plan.** Monitoring should be on a random basis, and urine samples should be taken under direct observation of a trained substance abuse worker. Breath analyzer tests can be administered with an intoximeter. It is a brief and inexpensive test.

Monitoring provides structure for the substance abuser. Frequently, the client lacks inner structure for control, and monitoring assists the client. It also frees the clinician-client relationship from possible manipulative aspects, because eventually the clinician will recognize drug use. **It is best not to make definitive clinical decisions on the basis of one breath analyzer or one urinalysis. One**

should base clinical decisions on patterns. It is also quite common for a clinician to be aware of a return to drug use before the breath analyzers or urinalysis data confirm the clinical suspicions.

6. **A rehabilitative treatment program should involve the family.** The family should probably not be defined as part of the problem unless one consults skilled family workers who make such a determination following extended family evaluation. The notion that a heroin addict or an alcoholic can become drug free without involvement of the spouse or significant others is a false one. It requires a major life-style change. **The family must be part of the network of care** and part of the information system developed around each client.

7. **A rehabilitation treatment program requires formal assessment of the client's mental status. Substance abuse is frequently accompanied by other DSM-III diagnosable mental conditions, most notably depression and antisocial personality disorder. There is also evidence that phobias and perhaps minor mood disorders are overrepresented in addict populations as compared to community samples. These conditions may require independent psychological and psychopharmacological treatments.** There is no reason why they cannot co-exist with whatever treatments are necessary for the substance abuse disorder.

The clinician should be aware that traditional alcoholism treatment philosophy, encompassed but not exclusively defined by Alcoholics Anonymous, opposes psychiatric treatment during the first phases of recovery. Some authors have written that psychotherapy is contraindicated in alcoholic populations for the first two years of their participation in AA. This may be true for some clients, but there are others, such as those with diagnosable affective disorders, phobias, bulimia, or severe insomnia, who will require and benefit from independent psychiatric care in addition to the substance abuse treatment program.

8. **The use of a community based program.** In treating substance abusers, a referral to Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous, Pot Anonymous or--in the instance of family members--Alanon and Alateen, is an indispensable element in the treatment program. Clients with substance abuse disorders will gain a sense of affiliation, have a new social network free of pressure to use intoxicants, and will have examples of successful abstinence-free living as a near-daily part of their experience.

No clinician should ever miss the chance to refer a family or family member who comes into the office stating, "My husband drinks himself asleep every night and he is rarely available to me for conversation; our sexual life is almost nonexistent. It has been this way for years and he will not listen or go for help. Is there anything I can do?" The clinician should refer that client to Alanon or, if the story centers on drugs of abuse other than alcohol, to Families Anonymous. These organizations are usually listed in the Yellow Pages in most communities in the United States.

9. **A possible use of a recovering substance abuser.** In addition to AA, a clinician may be aware of recovering substance abusers in the community who can be of very real assistance in helping clients form social networks free of pressure to use intoxicants.

10. **Pharmacological measures.** A number of specific pharmacologic agents such as blocking agents for opioid dependence, narcotic

substitution therapy with methadone, and disulfiram for alcoholics are other possible elements in the treatment package.

11. **Counseling or psychotherapy. There is controversy about the utility of psychotherapy in the initial stages of recovery.** In my opinion, psychotherapy can add a valuable dimension not obtainable through contact with AA or NA. Ideally, as the clinician acquires more experience with substance abuse, he or she will be able to help the client maintain a relationship with AA or NA groups and modulate the need for counseling. Psychotherapy will not be applicable, appropriate, or effective with every substance abuser, but it should be tried. Some eminent clinicians, including Zuska and Pursch, consider psychotherapy contraindicated in alcoholics until they achieve one to two years of sobriety and are involved in AA.

12. **General health measures. A complete physical and medical history of each client should be obtained and appropriate therapy offered.** The frequent use of potent amounts of psychoactive substances on a regular basis has negative biological and psychological consequences. I have reviewed the medical conditions commonly associated with various forms of substance abuse. (See the list of further reading at the end of this lesson.)

13. **Education concerning psychoactive drugs.** Education is a routine part of rehabilitative treatment plans with substance abusers. Usually clients will have counterculture beliefs or ideas about alcohol that are promoted by advertising. For example, the notion that alcohol enhances social desirability and sexual functioning, promotes masculinity or femininity, and is associated with daring and with good times. **It is important that such belief systems be attacked** by providing data.

Many younger persons with dependence on cannabis will essentially regard cannabis as a non-drug, something akin to a vitamin. The data concluding that cannabis smoking may have pulmonary consequences similar to smoking nicotine cigarettes are important antidotes for such attitudes. Effective client materials may be ordered the Addiction Research Foundation and from the National Institute on Drug Abuse. The information is inexpensive and effective. (See list at the end of this lesson.)

14. **Regular appointments with the rehabilitation practitioner.** The rehabilitation counselor or psychologist can be an important beacon in a family's attempt to help a member manage a substance abuse problem. One can refer clients to a substance abuse program and still maintain quarterly, bimonthly, or perhaps monthly contact. As a service coordinator and case manager, the rehabilitation counselor can follow up medication treatment regimens, offer family counseling, and assist with appropriate referrals.

15. **If the client is physically dependent, the consulting physician may recommend hospitalization,** particularly if the degree of dependence is moderate or severe. For example, someone using 20 to 30 barbiturate or methaqualone pills a day will not be detoxified successfully on an outpatient basis and will need hospitalization. Someone dependent on benzodiazepines in multiples of therapeutic doses of two or more will probably require hospitalization for a safe detoxification. Opioid dependence is an exception. Opioid dependence can be treated in a hospital, but there is no threat to the safety of a person from slow outpatient detoxification.

16. **Put the client in charge of his or her substance abuse rehabilitation program.** The rehabilitation practitioner should be co-worker in the client's primary efforts toward recovery.

FURTHER READING

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QUESTIONS BASED ON THIS LESSON

25. Which of the following statements is/are correct?

A. The earlier in life substance abuse begins, and the higher the lifetime dose, the likelier the complications will be more serious

B. In assessing a client for substance abuse, one should never ask about specific drugs

C. Knowing the context within which a client is more likely to abuse drugs is of little value in planning treatment

D. The distinction between hallucinations or delusions experienced in the context of drug abuse and such symptoms predating drug use has no clinical value

26. Which of the following statements is/are correct?

A. The hallmark of withdrawal symptoms is delirium

B. Drug-dependent persons usually report their control over drug taking is constant and strong

C. Most drug-dependent persons report frequent attempts to stop or cut down because they are aware of the negative consequence

D. A history of convulsions rules out the probability of substance abuse diagnosis

27. In substance abuse rehabilitation, which of the following statements is correct?

A. It is sometimes prudent for the rehabilitation practitioner to consult an attorney before releasing client information

B. The clinician should be familiar with and be able to knowledgeably use street language

C. Denial on the client's part is worsened if he or she sees the clinician as someone trying to help him

D. The rehabilitation practitioner should project a casual image and avoid confrontations

over, please...

28. In substance abuse rehabilitation, which of the following statements is correct?

A. Individual psychotherapy is superior to any planned substance abuse treatment program

B. Short-term programs are much more effective than long term ones

C. Monitoring the use of abused substances during rehabilitation treatment contributes to client paranoia and should never be done

D. Substance abuse should be regarded as an independent problem, but other concurrent psychiatric conditions should be appropriately treated as well

Directions in Rehabilitation Counseling

VOLUME 1 • LESSON 8

Current Developments in Group Psychotherapy

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EDITOR'S NOTE

Since the major influence of Freud's psychoanalytic theory, pioneers have continued to expand our theoretical understanding, technical expertise, and clinical application in using groups for psychotherapeutic purposes. Early developments included application of psychoanalytic group theory to "natural" groups (Bion); development of psychodrama and sociometric techniques (Moreno); and systematic treatment of group psychotherapy (Bach). Since the early 1950s, this maturation process has advanced because of an increased emphasis on theoretically significant research which has enabled an empirical basis for conclusions about group psychotherapy.

In this lesson, Dr. Spitz highlights recent literature exploring the role of group therapy in five specific clinical situations: 1) borderline personality disorders; 2) medical illness; 3) psycho-geriatrics; 4) chronic psychiatric disorders; and 5) sexual and marital problems. These clinical guides have particular relevance for rehabilitation counselors and psychologists who use group psychotherapy to address diverse clinical problems in medical and psychiatric settings.

The author then discusses methods for improving group entry and participation. Client selection, pre-training, group social climate, and leadership style are addressed. Strategies for preventing member drop-out and therapist error are also noted.

A summary of trends in group psychotherapy concludes the lesson. These trends include: 1) judicious use of self-disclosure by group leaders; 2) positioning group process within the framework of rehabilitative treatment planning; 3) using groups for education and skills training; 4) expanding group techniques to include insight-oriented approaches and eclectic leadership styles; 5) scientific evaluation of group models; and 6) attending to critical aspects of the pre-group period.

Introduction

Growth in the field of group psychotherapy over the past 30 years has resulted in expanded theoretical understanding, advanced technical expertise, and broader clinical applicability in managing diverse aspects of mental health and illness. To help conceptualize the "state of the art," one may examine major emerging trends as they reflect patterns of current rehabilitative practice. Six representative areas have been delineated in order to present a cross-sectional view of present efforts described with frequency and enthusiasm in the current group-psychotherapy literature.

Borderline and Narcissistic Disorders

Management of psychiatric clients diagnosed has having borderline or narcissistic personality disorders affords an opportunity to study the ways in which traditional group methods have been modified to meet the needs of a special client population.

The importance of clinical diagnosis in considering borderline and narcissistic clients for group placement cannot be overemphasized. A comprehensive evaluation must take into account intrapsychic, interpersonal, and environmental variables. **Before placement in group therapy, clients benefit from evaluation along the following parameters: ego structure, temperament, character traits, psychological-mindedness, and motivation.** In addition, **group leaders can utilize phenomenological, historical, and socioeconomic data to obtain a comprehensive profile of a prospective group member**. The profile enables an informed appraisal of the individual's likelihood of meshing or clashing with the proposed group membership and/or leadership. **Most experienced group therapists advocate intensive pregroup evaluation** and study to prevent inappropriate placement of borderline or narcissistic clients in groups.

Wong[1] conceptualizes group work as having five focal considerations: **clarity in defining diagnostic criteria, choice between supportive and reconstructive treatment, a decision on the value of simultaneous individual and group psychotherapy,**

homogeneity or heterogeneity in group composition (all borderline or groups of mixed diagnoses), **and the possibility of more than one group experience. He favors combined individual and group therapy conducted by the same therapist and suggests that the groups be varied in diagnostic composition.**

Expressed advantages of the combined treatment model over group or individual therapy include a greater sense of continuity of treatment focus and the ability to work on individual and interpersonal issues simultaneously. Options for management of troublesome transferential and countertransferential themes are increased. **The borderline client in individual therapy often has a stormy relationship with the therapist. Reality testing presented by other group members who share the therapist helps lessen extreme transference reactions.** Group members function as interpersonal buffers for the borderline client who is excessively anxious about being too close to the therapist. The group leader in a combined model can utilize the peer vector of the group to elucidate and resolve transferential roadblocks.

Recent group therapy literature clearly calls for revision of older, rigid group models in order to make group therapy a viable treatment option for borderline and narcissistic clients. Careful attention to pregroup screening, diagnosis, member selection, and client preparation reduces the chance of problems in group treatment. When these factors are effectively managed, the value of groups for the borderline population is enhanced. Horwitz[2] has summarized this most clearly in enumerating the reasons why group therapy is applicable to the overall treatment plan. He cites the following **seven advantages**: (1) groups provide **an opportunity for dilution of transference** by supplying several targets; (2) when necessary, clients can achieve **greater social and emotional distance**; (3) groups often induce a **greater reality orientation** and guide the client toward **appropriate social responses**; (4) borderline clients who are schizoid and withdrawn benefit from the **stimulation and activation of group interaction**; (5) borderline clients frequently have brittle controls over hostile impulses and may

respond to peer pressure in controlling these emotions in a group more readily than in a dyadic relationship; (6) opportunity for **identification with the therapist and other clients may facilitate consolidation of ego identity** and more adaptive impulse-defense configurations; (7) group interaction **highlights certain maladaptive character traits**–such as oral greed, inability to share, and pathological narcissism–and hence may effectively modify those traits.

While specific styles of intervention vary depending upon the group leader's theoretical orientation, there is growing consensus that the combined individual and group therapy format has much to offer in the integrated psychotherapeutic management of borderline and narcissistic clients.

Medical Rehabilitation

Psychotherapeutic group experiences for clients having varied medical conditions have gathered momentum in recent years. The purpose of these groups is at least twofold: **to help members comply with medical or surgical treatment plans and to define and treat psychological factors that contribute etiologically or are by-products of serious physical illness. Stress reduction and the acquisition of effective stress management skills** form the mainstay of some of these groups.

The array of medical conditions and types of clients for which groups have been designed is impressive. Group work includes: dialysis clients; clients with coronary disease, multiple sclerosis, irritable bowel syndrome, cancer, type-A behavior, asthma, psoriasis, hypertension, epilepsy, chronic pain, arthritis; postoperative amputees; children with cerebral palsy and other neurological conditions; kidney transplant clients. Despite the outwardly disparate nature of these groups, they share many common goals.

Groups for somatic conditions generally provide an educational component for their memberships. **The overwhelming majority of groups described in the literature**

are composed homogeneously for an illness experienced by all members. This homogeneity both facilitates entry into the group and forms a building block for early group cohesiveness. Since all members are matched for common medical illness, it is easier to utilize common group themes to engage clients who might resist or resent defining themselves as being in need of psychological help. Such clients are at high risk of declining or dropping out of psychotherapy. Consequently, one of the central goals of these groups is to offer clients a more palatable vehicle for sorely needed treatment services.

A second overall goal is to **help clients live more realistically and comfortably with their disease.** The peer-support and staff-support elements of the group are important influences in achieving this objective. Group membership helps counter feelings of uniqueness, freakishness, disfigurement, or social isolation and helps preserve and build healthy self-esteem among participants. In this process, another goal emerges: the importance of sensitizing health-care staff to the emotional vulnerabilities and needs of clients with medical illness.

The impact of clients' debilitating or chronic diseases upon individuals and families is a focal point for group discussion. Most groups make an organized effort to involve families and support systems in a constructive way. Encouraging clear, open communication among client, family, and rehabilitative health care team members is an intrinsic element of these group approaches.

Group **studies on coronary disease serve as a prototype** for many current group designs in the field of general hospital psychiatry. These can be conceptualized as follows: (1) early intervention is valued; (2) spouses and significant figures in the client's life should be encouraged to participate in treatment plans; (3) **therapists need not be physicians but should be informed about physical and psychological risk factors**; (4) many physically ill clients are not suited to intensive, self-disclosing, insight-oriented, longer-term individual therapy and should be approached instead with methods that emphasize supportive, educative, and behavioral components.

Programs in some settings feature adjunctive groups that are focal, task-oriented, time-limited, and largely behavioral. They are designed to control or eliminate destructive habit patterns. In the case of coronary-prone clients, these would include group efforts to help members stop smoking, give up excessive use of alcohol, reduce weight, or deal with specific concerns of the postcoronary client–for example, work resumption, and sexuality issues.

Geriatric Rehabilitation

Problematic issues of older adults are an area of increasing interest and research. With an appreciation of concerns faced by aging people has come a significant body of group work tailored to meet specific needs of this population.

Groups have become prominent in psychosocial management of geriatric clients for many reasons. **The constriction and attrition of age peers increase with time. The resultant feelings of isolation, dysphoria, and loneliness can have a dramatic effect on the quality of life for older people.** This, coupled with a growing concern about emotional or physical deterioration, places the geriatric client at risk of developing serious negative psychological sequelae.

These factors prompted the search for innovative and thoughtful group programs to help older adults. **Geriatric groups focus on the following objectives: socialization, problem-solving, and competency; support; senior actualization and growth; interpersonal skill training; expressive psychotherapy; and resocialization.**

Group services encompass preventive, therapeutic, supportive, and rehabilitative goals. Many centers utilize groups in conjunction with other critical services for geriatric clients: crisis intervention, appropriate placement services, home visits, family therapy, transitional residential care, and inpatient treatment.

A representative survey of different group formats reveals **an increasing affinity for structured, often behaviorally oriented, and supportive group models.** The work of Lesser and colleagues[3] represents an example of an innovative format used with psychotic geriatric clients. **"Reminiscence group therapy" differs from traditional group therapy in being structured and theme-oriented.** Members are requested to discuss a historical topic--e.g., their first day at school, first date. This serves as a catalyst for group interaction and provides a constructive matrix through which geriatric group members may become engaged. Group silences were noted to diminish, and questions about non-group-related issues were markedly reduced, as were pseudo-confusion and group lateness and absences. Direct intermember confrontation increased; passivity and apathy, prevalent in these groups, were replaced by a more animated group climate.

The literature also shows behavioral modification therapies addressing problems of the elderly. **Structured behavioral therapy to promote group participation by elderly depressed clients is prevalent today.** Behavioral groups are often believed advantageous in stimulating group interaction, lessening awareness of depressed feelings, and providing members with greater overall treatment satisfaction.

Loss of spouse is another stress that frequently befalls older adults. **Group experiences for widows** are discussed in the group literature in two major forms: **self-help groups (often leaderless) and groups conducted by mental health professionals.** In self-help programs, peers receive training and then conduct community-based educational programs to help the surviving spouse manage the bereavement process.

In groups of another type, there is often a special place for a group facilitator. Usually the facilitator is a woman who has experienced the loss of her husband and has made a successful life adjustment. The facilitator serves at least two purposes: **as a role model**, she indicates that successful adaptation is possible, and she serves an **educational function** by being uniquely able to **identify for recently widowed women the expected stages of the grief and mourning process.**

Problems faced by older widows emerge as core-group themes. Issues that occur with regularity and are confronted in older widows' groups include: difficulty managing guilt and anger; changing relationships with adult children; decision making, financial management, and legal arrangements; fears of being alone; and struggles in overcoming depression. Central goals of geriatric group therapy are: stress management, health maintenance, disease prevention, education, support in mobilizing psychological resources, sharing of tasks, cognitive guidance in handling life crises, and promoting a sense of personal responsibility.

Psychiatric Rehabilitation

For many years, group therapy has been concerned with treatment of the chronic and severely impaired psychiatric client. Today this emphasis is as strong as ever, and it has resulted in numerous articles devoted to aspects of managing psychotic inpatients and outpatients in groups.

The literature suggests that groups are particularly useful for the client who has had more than one psychotic break and for whom the rehabilitative process is difficult. This is most clearly manifested in difficulty with **interpersonal skills, resolving family problems**, and effectively **utilizing community support options**. Groups are also helpful in providing a vehicle for regular opportunities to **socialize in a safe, controlled setting.** In addition, groups offer a medium for **problem sharing** and serve as an outlet **for discharged clients in expressing tensions** stemming from work and the vicissitudes of daily life.

Keith and Matthews[4] make several cogent observations regarding the pros and cons of group therapy as a form of psychosocial treatment of clients with schizophrenia. First they note favorable factors, such as the economy of professional staff time and the cost efficiency that group therapy in general affords. They also acknowledge the ability to adapt other techniques for use in a group setting. Concurrently, however, they advise caution in several key areas, especially the timing of group intervention. Evidence indicates **groups work best after the resolution of florid psychotic symptoms**. Furthermore, groups of a more traditional and disclosing nature may be deleterious during the acute phase of a psychotic episode. Milieu-therapy literature and studies on the emotionally charged nature of schizophrenic families attest to the need for a stimulus-reducing environment, especially in the acute phase of the illness. Finally, what is termed "group therapy" is loosely defined. **Often groups are given lower status on inpatient services or in outpatient departments and may be led by less highly trained professionals. These factors may foster negative pretherapy expectations by clients and staff.**

While in principle there is agreement concerning the general usefulness of groups for chronic clients, there is considerable divergence in the literature regarding the array of techniques advanced to realize the goals. Mosher[5] conceptualizes that in order to be useful for schizophrenic clients, the focus of therapy encompasses seven distinct areas: (1) **discussion of day-to-day problems**; (2) **sharing relevant experiences**; (3) **learning to listen and thus becoming more sensitive to the needs and feelings of others**; (4) **offering new perspectives on situations being discussed**; (5) **asking questions**; (6) **expressing contrary opinions without fear of criticism**; and (7) **keeping a topic in focus until a conclusion is reached.**

From an analysis of the varied points of view expressed in the group psychotherapy literature, the rehabilitation clinician can extract valuable general principles felt most advantageous to the chronic psychiatric client and referrable to the group climate and leadership style. Factors common to many approaches include: gentle confrontation, high support elements, active leadership (especially around structuring and defining the group norms), liberalization of group standards based upon acceptance of realistic limitations of clients, and an avoidance of dwelling on delusional material. **Cotherapy or multiple leadership and an evenhanded leadership style that avoids extremes of behavior (charismatic or passive) are considered most conducive to beneficial change.**

Additional variables which contribute to the utilitarian aspect of groups are: the abilities to **define modest and realistic goals,** to **identify and work with client's strengths,** to **offer some immediate reward,** to **emphasize skill acquisitions**, and to use groups to **monitor pharmacological, interpersonal, and individual needs**.

The roles social networks and support systems play in mental health in general, and schizophrenia in particular, are significant. This awareness has resulted in therapeutic efforts that involve the natural groups of the chronic client. The group-therapy version of this theme is evident in the recent surge of interest in multiple-family group therapy. **Multiple-family groups may be viewed as intermediate between a psychotherapeutic and self-help group model**. They often employ team leadership, with careful selection and matching of families. The leaders attend to the group focus and effectively channel and direct the group process.

Tucker and Maxmen[6] originally categorized the potential of multiple-family groups for psychiatric inpatients. The principles they delineated are useful in explaining current clinical enthusiasm for multiple-family groups with the chronic client. **General functions served by these groups are:** (1) deisolation, (2) socialization and support, (3) imparting of information, (4) catharsis, (5) problem solving, (6) therapeutic competence, (7) instillation of hope, (8) client support, (9) interfamily learning, (10) facilitation of group therapy, and (11) data source. This conceptual scheme is clinically useful in understanding the goals and methods employed by those who advocate the multiple-family approach as a treatment option for chronic clients.

Also noteworthy is the work with affective disorders and groups. **Long-term homogeneous outpatient group treatment of manic-depressive illness is another**

popular approach being used. These groups are conducted in conjunction with lithium maintenance treatment and are aimed at getting clients to **comply with pharmacotherapy regimens.** Advocates of groups for clients with bipolar affective disorders feel groups offer stability of treatment for a population notorious for poor compliance. Early research findings on outcome suggest that rehospitalization rates may be significantly reduced by using combined lithium maintenance and outpatient group therapy.

In principle, group treatment of chronic clients, schizophrenics, and manic-depressives parallels Keith and Matthews's observations about psychosocial treatment of schizophrenia. They observed that group therapy is most effective in "ameliorating negative symptoms or in improving social competence, not at alleviating positive symptoms" of the primary conditions.

Sexual and Marital Problems

There is growing interface between group and family therapy. This is reflected in a body of work that addresses the treatment of dyadic relationship issues in the context of group psychotherapy. Two prominent examples are group approaches to sexual dysfunction and group methods for the treatment of marital problems.

The types of groups commonly used in treating sexual difficulties are: same-sex groups without partners, (e.g., an all-male group for premature-ejaculation problems) and mixed male-female groups (e.g., sexually dysfunctional married couples). Group composition and leadership style are significant variables. **Homogeneous groups addressing specific sexual symptoms usually require a more behavioral leadership style with a structured, time-limited group format. Out-of-session "homework" and an educational component are usually included in such groups. Heterogeneous groups of sexually dysfunctional members, however, are based upon more traditional interactional group psychotherapeutic models which incorporate specific**

behavioral elements. Intrapsychic and interpersonal themes are incorporated into the goals of heterogeneous groups.

Dominant themes in recent reported work center on expanded use of same-sex groups designed to help with specific elements of sexual dysfunction. For example, **primary anorgasmia and situational orgasmic problems are effectively treated in women's groups.**

Treatment of couples in groups, when sexual dysfunction is not the primary complaint, is another practical and widespread form of therapy. Spitz[7] has reviewed couples group therapy and the use of cotherapy in the small-group milieu of conjoint therapy for marital problems. In many ways, the results of couples group therapy parallel the outcome research on marital therapy. Based on current research data, two general sets of variables appear particularly helpful in group psychotherapy. **(1) Behavioral group methods are clearest in describing actual technique and in assessing treatment methods. (2) Setting short-term, focal treatment goals, incorporating structured communication training by leaders skilled in the dynamics of relationships, has proven effective.**

Pretraining, Client Selection, and Group Dropout Prevention

Recent research has been designed to improve meaningful group entry and participation and to reduce the likelihood of adverse responses, either as premature dropouts or as clinical casualties directly traceable to group events. This portion of the group literature addresses preventing avoidable "mistakes" stemming from leadership deficiencies.

Pretraining as it relates to groups in terms of process, outcome, attendance, and retention is a focus of current research. Studies have shown that **pretrained members tend to do better along these dimensions than do members who have not been pretrained.**

Pretraining appears in the literature in varied forms. Pretherapy formats of shorter or longer term are useful for various client populations. **A major school of thought employs pretraining to facilitate group experiences for clients who are generally regarded as difficult prospective group members.** Historically, much of this work was done with schizophrenic clients. There have been recent reports, however, of also successfully using pretherapy with other client populations. Adolescent groups are an area currently being studied which utilize pretherapy training. These models deal with the special problems in group structure and preparation that are most commonly encountered in adolescent groups. Several methods utilize behavioral contracting, establishment of clear guidelines, and programmed pretraining to foster development of verbal and interpersonal skills. **Specific advantages that result include a more rapid development of group cohesion, increased positive expectancies for treatment, reduced time spent in irrelevant group discussion, decreased confidentiality concerns, and facilitation of participants' skills in giving and receiving verbal feedback.**

Factors that increase the likelihood of clients' dropping out of groups represent another critical area of group psychotherapy research. This problem is addressed from three prevailing viewpoints: studies of curative factors inherent in groups; analysis of the role(s) of therapist, client, and environmental variables; treatment expectations and interpersonal behaviors that influence outcome in group therapy.

The theme of therapist error appears in several studies. **Inability to handle problem clients** (e.g., help-rejecting complainers, group monopolists); **difficulty adjusting from a dyadic model to a group model; and issues reflecting technical errors or countertransferential problems constitute the most difficult leadership issues for beginning group therapists.** Negative effects of self-disclosure by group members and leaders are another source of growing concern. **The detrimental effects**

of indiscriminate insistence by therapists for high degrees of self-disclosure, especially with lower-functioning clients, is noted in many clinical circles.

Observations regarding group size afford a specific illustration of the concern evident in the aforementioned research. **Group size as a factor in therapeutic outcome is crucial, especially when groups shrink to less than four members. When this occurs, group members often become frustrated and disappointed with group therapy.** Undesirable group norms are likely to develop. These norms are characterized by conflict avoidance, equal time for each member, therapist activity, client passivity, obligatory intermember feedback, and a leader-centeredness in which group members abdicate individual responsibility for determining group direction. **Group image--the group parallel of self-image in individual psychotherapy--is strikingly negative in groups of insufficient size.**

Optimal size for an outpatient interactional group **with one leader is five to nine members, or a maximum of 12 members with two co-leaders**.

Research described in this section is noteworthy because it reflects a major trend in the field of group psychotherapy. In recent years there as been a departure from an anecdotally-based body of literature to one with a scientific orientation. Current trends document specific elements contributing to clinical favor in group psychotherapy.

Summary

Current developments in group psychotherapy may be summarized as follows. (1) **Encouraging activity and judicious use of self-disclosure by group leaders;** (2) **endorsing group psychotherapy as part of integrated treatment models;** (3) renewing interest in groups as a vehicle for **education** (i.e., acquiring concrete information and **mastering specific interpersonal skills**); (4) reinforcing the value of psychodynamic groups approaches and expanding these approaches to include elements that

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enhance insight and yield **eclectic leadership styles**; (5) insisting on **systematic, scientific evaluation of all group models;** and (6) attending to **critical aspects of the pregroup period** (i.e., screening, diagnosis, client preparation).

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QUESTIONS BASED ON THIS LESSON

29. In selecting a group therapy situation for borderline clients, Wong recommends that:

A. Group therapy be carried out without individual therapy

B. Different therapists be employed for individual and group sessions

C. Diagnostic composition of the group be heterogenous

D. Diagnostic composition of the group be homogenous

30. In group therapy for clients with coronary disease:

A. Families should not be included

B. Therapists need not be physicians, but must be informed about physical and psychological risk factors

C. All clients should receive intensive, self-disclosing, insight-oriented therapy

D. Heterogenous group composition is preferred

31. Group therapy for chronically ill psychiatric clients:

A. Is useless for clients who have had more than one psychotic break

B. Usually interferes with rehabilitative efforts

C. Can be a profitable way to learn interpersonal skills

D. Works best during florid psychotic phases

32. Pretraining for prospective group therapy clients:

A. Should not be used for clients who may prove especially difficult in the group setting

B. Tends to retard the development of group cohesion

C. Heightens most clients' concern about confidentiality

D. Seems to improve members' subsequent participation in therapy

Directions in
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VOLUME 1 • LESSON 9

Obsessive-Compulsive Disorder: New Findings

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EDITOR'S NOTE

With recent advances in genetics, neuropharmacology, and neuropsychology have come new findings about the etiology and treatment of obsessive-compulsive disorder (OCD). During the past three hundred years, varied causal explanations for this psychiatric disorder have been presented, with current findings reflecting a neuro-biological basis. Etiological studies have, in turn, prompted refinement of treatment modalities. A multi-modal approach, incorporating behavioral techniques and pharmacologic treatment, has gained favor in the psychiatric rehabilitation of patients with OCD.

An anxiety disorder, OCD carries the essential features of obsessive thoughts that are ego dystonic and compulsive behaviors which the individual feels compelled to perform. While recognizing what they are experiencing is inappropriate, individuals with OCD seem unable to control their distressing thoughts or behaviors.

OCD shares many features of affective illness, with major depressive episodes occurring in at least 50% of OCD patients. In contrast with affective illness, however, OCD tends to be more chronic, shows a younger age of onset, and has a lower ratio of female-to-male incidence. Similar to phobic disorders, OCD is usually characterized by avoidant behavior. For the OCD patient, however, avoidance usually does not prevent anxiety. Unlike individuals with major psychotic syndromes, OCD patients retain insight.

Four syndromes are particularly common among individuals with OCD. 1) About 50% manifest obsessions with dirt, contamination, germs, and bugs. They engage in compulsive washing. 2) The pure obsessional, representing about 25% of OCD patients, describes repetitive, intrusive, reprehensible thoughts, usually of a sexual or aggressive nature. 3) Another symptom involves pathological doubt, accompanied by compulsive checking. 4) Primary obsessional slowness, a rare form of OCD, has extreme slowness as its predominant symptom.

In reviewing rehabilitative treatment approaches, Dr. Insel notes that nondirective psychotherapy has been largely unsuccessful in reducing symptoms of OCD. Recent neuropsychologic studies using imaging techniques appear promising. These findings suggest that frontal-striatal pathways in OCD may be an important treatment focus. Behavioral therapy, using in vivo exposure and response prevention, has been successful with 80% of OCD patients. This therapy, however, may be inappropriate for some individuals. Pharmacologic treatment may also prove useful. Clomipramine, a potent blocker of the neuronal reuptake of serotonin, is being studied toward FDA approval. Fluoxetine (Prozac) has a similar biological influence.

Introduction

Obsessions and compulsions are present in a variety of psychiatric conditions including mood disorders, schizophrenia, anorexia nervosa, and Tourette's syndrome, as well as in normal mental functioning. A unique syndrome for which obsessions or compulsions are the primary symptoms and the major source of disability has been recognized for more than three centuries. **That condition, which we now call obsessive-compulsive disorder (OCD), was previously known as scruples, religious melancholy, or obsessional neurosis.** Although the disorder has changed very little over the centuries, explanations for its cause have ranged from religious to psychosexual, in keeping with the prevailing intellectual theories. In the current era, advances in genetics, neuropharmacology, the neuropsychology have increasingly dominated our search for the etiology of psychiatric illnesses. Accordingly, the new findings in OCD reflect a neurobiological basis. The usefulness of that approach may ultimately depend less on determining an etiology and more on providing new therapies for this mysterious disorder.

Diagnosis

Obsessions are cognitive symptoms; compulsions are ritualistic behaviors. The most recent attempt to define criteria for the syndrome is shown in table 1.[1]

The following points about the diagnosis of OCD deserve special emphasis. **Unlike individuals with obsessive-compulsive character disorder, persons with OCD complain of ego-dystonic symptoms** ("I know that it is stupid to be so concerned about trivial things, yet I have to check them again and again. It's like beng on remote control."). **OCD** patients tend to be seen as people with compulsive characters who have decompensated. Although the names are similar and the two diagnoses share several defense mechanisms (e.g, reaction formation, undoing, and displacement) many patients with OCD do not have compulsive characters.[2] Indeed, those with OCD are more likely to manifest such premorbid traits as introversion and dependence rather than classic obsessionality. Rapoport and her coworkers have followed children with OCD prospectively to determine the relationship of "trait" and "state" obsessionality.[3] Their data suggest that OCD children manifest few if any obsessional character traits prior to the onset of the disorder. Years later, after a long struggle with OCD, many of those children showed more of the rigidity, stubbornness, and emotional constriction usually associated with the obsessional character. Those traits may thus be secondary to the disorder rather than etiologically linked to OCD.

Unlike those with major psychotic syndromes, OCD patients retain insight ("This thought about contamination is crazy, but I still have to wash my hands, and that's what bothers me so much."). That distinction, which may seem obvious in most patients, is integral to almost all definitions of the syndrome. Unfortunately, the presence of insight is equivocal for a substantial subgroup of patients. Those patients, who have been labeled either obsessive-compulsive psychotics or schizo-obsessives, appear either more bizarre or more disabled than those with the classic "neurotic" forms of the disorder.[4] It is becoming increasingly clear that such patients belong within the spectrum of OCD although they may be more resistant to treatment than most OCD patients.

TABLE 1
Definition of Criteria for OCD (DSM-III-R)

A. Either obsessions or compulsions

Obsessions: (1), (2), (3), and (4):

(1) Recurrent, persistent ideas, thoughts, impulses, or images that are experienced as intrusive, unwanted, and senseless or repugnant (at least initially).

(2) The person attempts to ignore or suppress them or to neutralize them with some other thought or action.

(3) The person recognizes that the obsessions are the product of his or her own mind and not imposed from without (as in thought insertion).

(4) If another Axis I disorder is present, the content of the obsession is related to it; e.g., it does not include thoughts about food in the presence of an eating disorder, thoughts about drugs in the presence of a psychoactive substance use disorder, or guilty thoughts in the presence of a major depression.

Compulsions: (1), (2), and (3):

(1) Repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, or according to certain rules or in a stereotyped fashion.

(2) The behavior is not an end in itself, but is designed to neutralize or prevent discomfort or some dreaded event or situation. However, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent or it is clearly excessive.

(3) The person recognizes that his or her behavior is excessive or unreasonable.

B. The obsessions or compulsions cause marked distress, are time-consuming (take more than an hour a day), or interfere with occupational functioning or with usual social activities or relationships with others.

Similar to phobic disorders, OCD is usually characterized by avoidant behavior. However, for the OCD patient, avoidance usually does not prevent anxiety. The anxiety associated with OCD is generally secondary to an inner compelling force or expectation rather than to an external cue, such as that associated with a phobia. Indeed, one useful distinction between OCD and a phobic disorder is that in the former, avoidance cannot succeed. Although the OCD patient may describe her symptoms as a germ or contamination phobia, the actual cue is either invisible, ubiquitous, or unavoidable.

Symptom Clusters

It is curious that of all the ways one might obsess or ritualize, **patients with OCD present a relatively restricted repertoire of symptoms.** Four of the most common syndromes are described below.

Washing:

Representing about 50% of most OCD samples,[5] washers are obsessed with dirt, contamination, germs, or bugs. They may spend several hours each day washing their hands or showering. Concerns with contamination most frequently revolve around urine, feces, vaginal secretions, or some natural bodily process that cannot be avoided. Washers may become incapacitated by their rituals and, if they avoid public restrooms, may ultimately be unable to leave home. Resistance at times seems halfhearted. Although the patients states, "I know I am not really going to transmit cancer if I don't wash," one may find in him or her a truculent refusal to shake hands or to touch doorknobs. Occasionally, washers are not even certain why they are washing but express a vague presentiment that "something terrible will happen if I don't."

Checking:

A second presentation for OCD involves **pathologic doubt accompanied by compulsive checking.** Typically the "checker" fears the gas jets have been left on or that a bump in the road was a body; the doubts reveal a concern with violence. **Although some uncertainty about carelessness, particularly carelessness that could lead to catastrophic consequences, is common to us all, for the obsessional the uncertainty takes on a gnawing, malignant quality. Checking, which is enough to resolve "normal" uncertainty, often only contributes to the obsessional's doubt.** For instance, if after checking, a bump in the road does not appear to be a body, then the obsessional fears that the body may have been knocked into the bushes. **Ultimately, by some inscrutable means, the patient resolves one particular doubt only to have it replaced by a new obsessional preoccupation.** Rachman and Hodgson have described compulsive checking as "preventive," because the fears are often future-oriented, in contrast to washing, which is "restorative." **Resistance, which in this case is the attempt to refrain from checking, leads to difficulty concentrating and exhaustion from the never-ending assault of nagging uncertainties.** Checkers live as if they are the guilty party perpetually in search of a crime, and, unsurprisingly, they frequently describe a strict religious upbringing.

Pure Obsession:

A third clinical picture is that of the pure obsessional. **Approximately 25% of patients with OCD are in this category.[5] Repetitive, intrusive thoughts, usually sexual or aggressive and always reprehensible, may be associated with impulses (which have been called horrific temptations) or fearful images. When the obsession is an aggressive impulse, it is most often directed at the one person most** valuable to the patient and thus becomes an indirect attack on the self. Occasionally, the thought may seem relatively neutral to the observer, but for the patient, the preoccupation invariably seems laden with guilt. Resistance, which may involve cognitive (e.g., counting or counter-thoughts) rather than behavioral rituals, may be more bothersome than the original intrusive thought. A patient who was afraid he would decapitate his younger brother, struggled with that impulse by avoiding sharp objects, then avoiding his family, and ultimately avoiding letters of the alphabet contained in his brother's name. Each time he would encounter the word "ax" or his brother's initials, he went through an extensive mental "counter-ritual" to undo the image of decapitation.

Primary Obsessional Slowness:

The final presentation is the rare and disabling syndrome of primary obsessional slowness.[6] Although slowness is a consequence of most rituals, it occasionally becomes the predominant symptom. The person may take an hour or more to brush his teeth or two hours to eat breakfast. One such patient presented with stasis pigmentation of both ankles, a result of the 8 to 10 hours spent each day at the bathroom sink. Even though such patients may have extensive rituals and severe obsessional preoccupations, they manifest very little anxiety. For them, life grinds on at a remarkably low speed.

Those four presentations are clusters of symptoms but not entirely independent syndromes. In many cases, washing and checking co-exist. In addition, one sees adult patients with pure obsessional complaints who give a history of compulsive handwashing or compulsive checking during young adulthood. Thus, within individuals, the different symptom clusters may overlap or may develop sequentially.

Prevalence

The traditional reputation of OCD as "rare" is probably not accurate. Although **the administered prevalence (i.e., the number of OCD patients in a treatment population) is probably close to l%,** with some variance depending on the treatment center,[7] patients with the disorder are quite secretive, and, therefore, **one might expect the actual prevalence to be considerably higher.** The Epidemiologic Catchment Area study sponsored by the National Institute of Mental Health sought to establish the actual prevalence of several psychiatric disorders by administering the Diagnostic Interview Schedule in a door-to-door survey.[8] Results suggest an astonishing 1.3 to 2.0% of the general population meeting criteria for OCD. If that diagnostic method is validated and the results are replicated, OCD would appear to be more prevalent in the general population than in the psychiatric clinic. One might then wonder if that tiny fraction of obsessionals who become patients can truly be distinguished by their symptoms or if some other factor, such as family conflicts, depression, or a particular personality style, might determine when obsessionals become psychiatric patients. Alternatively, many OCD patients may be misdiagnosed in the psychiatric setting.

Little evidence is available to determine significant cultural or national differences in the prevalence of OCD. Description of the disorder from Asian, European, African, and American clinicians suggest remarkable similarities, although the preponderance of the various symptom clusters differs across settings.[9-11]

OCD is also one of the few psychiatric illnesses that is found

in children in a form nearly identical to its adult presentation. Perhaps the only distinguishing feature of the childhood form of OCD is that **boys appear more affected than girls, with a male-female ratio of three to one, whereas the sexes are equally represented in adult cohorts with the disorder.**[3] The overall prevalence of OCD may be slightly lower in children, although a comprehensive community survey remains to be done for children. As many as one third of adults with OCD admit to onset of symptoms prior to age 18, often prior to puberty.[11]

Genetics

Sophisticated adoption studies such as those used in research on schizophrenia and affective illness are not available for OCD. Studies of the families of obsessional patients have generally yielded a high incidence of obsessional "features" (noninterfering obsessional thoughts or behavior) but not of obsessional disorder per se.[12] A number of reports have described identical twins concordant for OCD. Although that might indicate a genetic component for the disorder, such data are always suspect to reporting bias, because discordant pairs are less likely to be reported. Systematic twin studies, while sparse, demonstrate high concordance rates in monozygotic twins but only when the measure is obsessional features, not full-blown OCD.[13] The picture that emerges from those studies is that **some predisposition to obsessional behavior is inherited; but, consistent with the preliminary epidemiologic data, the development of the full disorder leading to treatment appears to be an uncommon event.**

Pauls and coworkers, in an important recent study of Tourette's syndrome, noted **OCD occurs in as many as 20% of the first-degree**

relatives of Tourette's patients,[14] a figure considerably higher than the corresponding number of relatives of OCD patients. In that study, many of the Tourette's patients also had obsessional symptoms, but, surprisingly, the high rate of OCD in relatives was not limited to those index cases with obsessional symptoms. It appears then that the two disorders, or some subtype of the two disorders, share a common genetic predisposition. Pauls and his coworkers are currently using the techniques of molecular genetics to determine if those pedigrees have a specific genetic abnormality. With those techniques it may be possible to localize the part of the genome that is altered in people with the disorder and to define specific gene products that result from this alteration. First, however, it will be important to determine what "disorder" to look for--Tourette's, OCD, obsessional features, or some combination of the three.

OCD and Affective Illness

More than most anxiety disorders, OCD shares many features of affective illness. Beyond the response to one particular antidepressant, studies of patients with OCD have revealed a number of neurobiologic abnormalities previously though to be specific to patients with major depression, including **an increased rate (25 to 40%) of nonsuppression on the dexamethasone suppression test (DST), shortened rapid eye movement (REM) latency during electroencephalographic recording of sleep, and blunted plasma growth hormone response to intravenous administration of clonidine. Those neurobiologic findings are not limited to patients with OCD who have secondary depression, nor are they predictive of response to antidepressant**

treatment. They serve to remind us of what perceptive clinicians have known for the past century: obsessional symptoms are intimately linked to changes in affect. **Not only are obsessions common in primary depressive illness, but major depressive episodes occur in at least 50% of OCD cases.** Some chronically obsessional patients only present for treatment when they become acutely depressed. And even in obsessionals who are not overtly depressed, affective-like symptoms such as low self-esteem, guilt, exhaustion, and indecisiveness are prominent.

Obsessive-compulsive disorder might then seem a variant of affective illness, as suggested in the last century by Maudsley. However plausible that may seem in individual cases, group data are not entirely supportive of that notion. **In contrast to affective illness, OCD tends to be more chronic, shows a younger age of onset, and has a lower ratio of female-to-male incidence. In addition, one retrospective study found OCD to have a lower incidence than a family history of depression,** but this is not true in all samples.

Neuropsychologic Findings

Several leads suggest neuropsychologic dysfunction in OCD.[15] **Many cases of OCD appeared to evolve as sequelae to encephalitis lethargica,** a disease with well-documented neuropathologic lesions. **Grimshaw reported a high incidence of premorbid neurologic illness in addition to encephalitis in his series of patients with OCD.** One report suggests patients with "atypical" symptoms have a high incidence of **birth trauma.** Obsessionalism is evident as an interictal trait in **temporal lobe epileptics.** And finally, **discrete neurosurgical lesions have been shown to selectively reduce obsessional symptoms.**

Despite those leads, no clear evidence of a specific neurologic dysfunction has been documented. There are **conflicting reports of EEG abnormalities in patients with OCD,** but even the most outspoken claims cite only nonspecific, nonlocalized findings such as increased slow-wave activity. Shagass and his coworkers have reported an increased amplitude in one of the middle latency waves of the somatosensory-evoked response. Unlike other findings of electrophysiologic abnormalities, this finding is distinct to OCD.[16] The patho-etiologic significance of that finding remains to be determined.

Recent results using new imaging techniques have been particularly intriguing. **Some young adults with OCD appear to show atrophy of the caudate nucleus on volumetric CT scans.**[3] **Positron emission tomography studies show increased metabolic activity in the orbital frontal cortex and caudate nucleus.**[17] Current research is leading toward a hypothesis regarding abnormal frontal-striatal activity in at least some patients with OCD. Although it is not yet clear if the abnormalities reported are of etiologic significance, **the therapeutic efficacy of surgically interrupting frontal-striatal pathways in OCD has been known for decades,** so that pathway may represent an important focus for treatment.[18]

Rehabilitative Treatment

Of all psychiatric conditions, OCD has generally been considered one of the most refractory to treatment. Patients with the disorder frequently present with symptoms seemingly laden with unconscious symbolism and dynamic meaning. Yet, **psychodynamic treatments, particularly if they are loosely structured and nondirective, often fail**

to reduce the symptoms. Behavioral approaches and pharmacologic treatments have recently been shown to offer considerable promise in OCD.

Behavioral Treatments:

Of the number of frequently used behavioral interventions, only two have been repeatedly successful of OCD, **in vivo exposure and response prevention.** Both techniques require a thorough knowledge of the patient's symptoms. **In vivo exposure includes contact with the objects associated with discomfort, contamination, or fear.** A patient with fears of contamination from urine will be exposed to public bathrooms and may ultimately touch a urine soaked cloth for two hours each day, until the dread of contamination subsides. In addition, the patient will not be permitted to wash, or at least not to wash excessively. **That restriction of washing, which is called response prevention, appears particularly important for decreasing compulsive behavior.** Indeed, careful studies by Steketee and coworkers have demonstrated that for decreasing both obsessions and compulsions, the two techniques should be used together.[19]

The best patient for behavior therapy is the washer or checker with well-defined external cues, associated avoidance, and high motivation for change. The therapy is built around risk taking, with the patient pushing himself or herself to do the very things that have seemed so reprehensible. Not every OCD patient is right for in vivo exposure and response prevention. **Those with depression and those with little resistance to their symptoms may not respond.** In addition, patients with pure obsessions or those with primary obsessional slowness may not be appropriate for such treatment. Perhaps the major limitation of this form of behavior therapy, however, is the therapist. Those techniques require a therapist with training and time. During the early phases of this treatment, the therapist may spend three hours a day with each patient. Clearly, if the disorder is as common as currently believed, that treatment can help only a tiny fraction of those with OCD.

Although behavior treatment is intense and difficult, as many as 80% of those who undergo in vivo exposure and response prevention are much improved within a few weeks.[19] Follow-up studies reveal continued improvement at one year following treatment, although in many cases the need for behavioral homework or brief "refresher" sessions may be helpful. Most important, OCD patients who undertake behavior treatment rarely develop "substitute symptoms" or psychosis, although patients usually fear one or both of those adverse outcomes.

Pharmacologic Treatment:

For those patients who will not undertake behavioral therapy or those for whom avoidant behavior is not a major part of the symptom picture, medication may be especially useful. The pharmacologic treatment of OCD has recently become an intriguing area of research as well as a promising avenue of therapy.[20] The major finding from studies in Europe, Canada, and the United States is that the tricyclic antidepressant clomipramine (Anafranil) reduces the symptoms of OCD, whereas a number of structurally related antidepressants such as desipramine (Norpramin, Pertofrane), amitriptyline (Elavil), and

nortriptyline (Pamelor) have not been found to be effective. Among antidepressants, clomipramine is distinguished by its potency for blocking the neuronal re-uptake of serotonin, which is the major route of metabolism of that neurotransmitter. Several lines of evidence link the drug's serotonergic and anti-obsessional effects. **Improvement during clomipramine treatment is correlated with decreases in the serotonin content of platelets and the serotonin metabolite, 5-hydroxyindole-acetic acid (5-HIAA), in cerebrospinal fluid.** Some, but not all, studies have observed a correlation between improvement in obsessional symptoms and the plasma level of clomipramine (but not its less-selective metabolite desmethylclomipramine). **Very recently, two other potent serotonin reuptake inhibitors, fluoxetine (Prozac) and fluvoxamine, have also been found to reduce the symptoms of OCD.**[21]

In addition to those findings implicating serotonin in the reduction of OCD symptoms, evidence grows that **OCD patients show altered sensitivity to certain serotonin-like drugs.**[22] **One such drug, meta-chlorophenylpiperazine, actually provokes severe obsessional symptoms in OCD patients at a dose that is without behavioral effects in healthy volunteers. This altered sensitivity is corrected by treatment with clomipramine.**[23] Further evidence that serotonin may be involved in the pathophysiology of OCD comes from reports of increased levels of 5-HIAA in the cerebrospinal fluid of drug-free OCD patients **(suggesting increased central metabolism or turnover of serotonin)** and decreased levels of the serotonin uptake site in platelets from OCD patients.[20] It may be too early to integrate the emerging data into a single model but, from a simplistic view, it is tempting to contrast OCD and its apparently increased 5-HIAA in cerebrospinal fluid with impulsive sociopathy--its phenomenologic opposite--which is associated with decreased cerebrospinal fluid 5-HIAA levels. Preclinical studies have demonstrated a role for brain serotonergic systems in the modulation of aggression.[24] It should not be surprising that OCD, which is replete with guilt and aggressive thoughts, might also involve some alteration of serotonergic function. During the next decade, we should learn more about which of the brain's many serotonergic pathways are involved in OCD and how those pathways alter OCD symptoms.

In the meantime, the major focus will be finding the best pharmacologic treatment. Although we now have several strong leads tying serotonin to the pathophysiology and/or pharmacologic treatment of OCD, some of the drugs of greatest promise are not yet available outside of a research setting. One exception is fluoxetine, which was approved for the treatment of depression late in 1987. Clomipramine and fluvoxamine remain under investigational status in the United States. **Until those investigational drugs become available, fluoxetine may be the best choice for an antiobsessional compound. In addition, several less specifically anti-obsessional antidepressants such as imipramine (Tofranil) or the monoamine oxidase inhibitors such as tranylcypromine (Parnate) may be useful. Whatever drug is used, our current experience suggests a prolonged trial (i.e., six weeks at full dosage) should be offered before assessing efficacy and that continuous treatment may be necessary if the drug is successful at reducing the target symptoms.** This latter point deserves emphasis. **None of the pharmacologic treatments are cures--patients continue to have some symptoms, but they appear less distressed and are usually able to return to work or school.** Frequently, however, the symptoms revert to their original severity when the medication is stopped.

Therapeutic Rapport

OCD is usually a chronic disorder. Whether its cause is ultimately genetic, neurologic, or biochemical, its treatment is likely to be multimodal, including behavioral and pharmacologic approaches. In addition, a good therapeutic rapport is necessary, if not sufficient, for treatment. **In many cases, the opportunity to explore both the intrapersonal and interpersonal meanings of the disorder may be welcomed by the patient.** Although such an exploration may not predictably reduce the symptoms of OCD, it may greatly help the patient adjust to any aspects of the disorder that do not respond to specific treatments and to build on strengths not affected by the disorder.

In OCD, perhaps more than in other psychiatric disorders, **there is often a very weak correlation between the severity of the symptoms and the amount of disability. Indeed, many people with years of extensive washing rituals seem to lead productive lives and only come for treatment when they develop a disabling depression. Conversely, as OCD receives more attention in the media, people with relatively mild compulsive symptoms who are disabled by severe character pathology are labeled as having OCD.** In both cases, the disorder may be present, but OCD need not be the focus of therapy. **In evaluating a patient for OCD, the interviewer should elicit the patient's past highest level of ego functioning as well as take a history of the various symptoms.** Similarly, treatment needs to address the entire person, not simply focus on the obsessions and compulsions.

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QUESTIONS BASED ON THIS LESSON

33. Obsessive-compulsive disorder (OCD):

A. Was once known as scruples or religious melancholy

B. Is another term for obsessive-compulsive personality disorder

C. Is never associated with such premorbid traits as introversion or dependence

D. Involves a significant loss of insight that usually approaches the psychotic

34. Patients with OCD:

A. Can avoid anxiety by avoiding the object of their anxiety

B. May experience concentration difficulty and exhaustion in their efforts to resist compulsive behavior

C. Represent about 15% of the general population

D. Are invariably over the age of 20

35. Which of the following statements about OCD is correct?

A. It is never seen among first-degree relatives of Tourette's patients

B. It never evolves as a sequellae to encephalitis

C. It shares many features of affective illness, as shown in neurobiological assessments

D. It is most commonly a defense against a full-blown schizophrenic breakdown

over, please...

36. In rehabilitative treatment of OCD, which of the following statements is ***incorrect***?

A. OCD is generally one of the most refractory psychiatric conditions to treat

B. Intrapersonal and interpersonal meanings of OCD should be explored by the patient in counseling

C. Behavioral and pharmacologic approaches have proven effective

D. Treatment should focus solely on the patient's obsessions and compulsions

Directions in Rehabilitation Counseling

VOLUME 1 • LESSON 10

The Criminal Personality

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EDITOR'S NOTE

Issues central to criminology and offender rehabilitation continue receiving attention from diverse disciplines. In recent years, debate has focused upon psychosocial profiles of individuals who commit crimes, causality factors, as well as offender rehabilitative treatment approaches. Theories of causality have ranged from an individual's genetic predisposition for criminal activity to familial and cultural influence. Rehabilitation has, in turn, been approached using varied techniques from numerous schools of psychotherapy. Many issues, however, remain unresolved and controversial.

In this lesson, Dr. Samenow addresses the "criminal personality" who requires fundamental "habilitation." A distinction is noted between the person who commits a single crime during a time-limited period of extreme emotion or stress and the "career criminal" whose life seems dedicated to pursuing a career in crime. The author describes distinctive characteristics of the career criminal who has unique ways of thinking, perceiving self, and responding to others. Assuming a victim's role, the career criminal is described as a concrete thinker who does not act impulsively, but in a deliberate manner when pursuing criminal endeavors. Intolerant of criticism, the criminal is an angry person able to conceal emotions behind a pleasant, albeit manipulative, facade. A sense of injury to others has no meaning for the career criminal.

In Dr. Samenow's opinion, the concept of "rehabilitation," with its primary goal of restoring clients to their previously healthy state, is a misnomer when applied to the career criminal, who has never practiced responsible living. More accurately, the objective is to "habilitate," or help the individual change the way he or she thinks. In discussing the habilitative process, the author presents an approach different from most traditional psychotherapies. For example, there is little emphasis on feelings. Rather than learning to verbalize anger, the career criminal must be taught to control anger. Motivation for change is based on negative self-opinions. If rehabilitation can indeed occur, it will result from the individual's fears about the consequences of his or her behavior.

Introduction

For decades, criminality has been perceived as a product of forces external to the individual or as resulting from a mental illness. Moreover, it is argued that the definition of criminality changes, depending upon the laws and mores of society. A person might be regarded as a "criminal" today but not tomorrow, according to the law. In other words, criminality is a relative concept. Those who hold these views reject the idea that there is a "criminal personality." They regard such a concept as a throwback to outmoded 19th century theories or as a dubious argument that there is a "bad seed." The concept of a "criminal personality" has surfaced again based largely upon the findings of a seventeen-year research-treatment program by Yochelson and Samenow.[1-4] Before discussing their concept, let us first examine why other long-standing explanations of criminal behavior are unsatisfactory.

Sociological Explanations

Nearly every environmental adversity has been cited as causative of crime. The conventional wisdom has been that poverty, racism, trouble-filled schools, and lack of employment opportunity have driven youngsters and adults into crime. Such thinking, however, has been based on sociological theories or on what criminals have told others when they are held accountable for their offenses. **Crime knows no social or economic boundaries.** Certainly if a person lives in a slum and does not know what or when he will next eat, this constitutes a severe hardship. Most poor people are not criminals, however, and many prosperous individuals are. Within a poor family, there are different ways in which its members perceive and react to adversities: Some may or may not turn to crime. People will argue that it is safer to walk in an affluent suburb than in most inner-city neighborhoods, but this may be explained by the fact that criminals often gravitate to areas of instability which are within the urban core. The locations in which they congregate are inhabited by many responsible citizens who are afraid to leave their homes.

The same sort of argument holds for other alleged environmental causes of crime. As mentioned above, schools have their problems, and there are parts of the country where unemployment is high. Again, **different people deal with social problems in different ways.** They choose how to respond. The conventional wisdom is that people become criminals because they are shut out of the mainstream--that they have a hard time in school and fail, or that they are unable to find work. The reality is that there are some people who reject the mainstream before the mainstream rejects them. They despise doing things on others' terms and find requirements of school or the workplace insufferably boring. The person who becomes a criminal may attend school or hold a job only because he hopes to provide to others a convincing facade of responsibility. Having satisfied others, they are then free to do as they please. Some use a classroom or job site as an arena for committing crimes. This is not meant to ignore the impact of serious social problems, but society does not cause crime. It may, however, provide opportunities for crime to occur by offering greater or lesser deterrence, but the role of individual choice has been understated or entirely overlooked. After all, it is the individual who chooses to commit a crime. Only later, when the offender is held accountable, does he contend that unfavorable environmental conditions are responsible for his having broken the law.

The above discussion has not addressed the matter of peer pressure which has long been regarded as critical to the etiology of criminal behavior. Anyone who raises a child or observes adolescents knows that **peer pressure is a powerful force nearly from womb to tomb. What is ignored is that peers are chosen.** Youths are not forced into crime at knifepoint. Every high school has its groups with a variety of names (depending on location and the particular terms in use), e.g. "preppies," "nerds," "jocks," "freaks." For example, to be a member of a group of illegal drug users who are committing crimes not only requires a series of choices, but also a determination to show that one can be trusted, will not "snitch" (or inform), and that one will go along with the group. Even in neighborhoods and schools where there is a significant criminal element, many youths reject participating in such activities.

Sociological explanations of criminal behavior fail to provide an answer as to why people turn to crime. Indeed, such explanations only provide rationalizations which render the criminal a victim of adverse forces that he cannot control.

Psychological Factors

A second major category of explanation for criminal behavior is psychological. **It has long been taken for granted that a great deal of what people do results from their upbringing.** If the child turns out to have problems, it is invariably believed that the parents must be at fault. The thinking, in turn, has been that if the offspring is engaging in criminal behavior, his home life must have contributed. Inadequate parenting, poor role models, and child abuse are among the factors regarded as causative of criminal behavior. **However, there are no findings to confirm this belief.** Again, **it is how the child perceives and reacts to adversity that is of critical importance. Child abuse is a case in point. In the first place, criminals may often lie and allege that they have been abused when, in reality, abuse has never occurred. Secondly, if one asks these individuals how their siblings were treated, they may candidly acknowledge that their brothers and sisters were not harshly treated because their behavior conformed to acceptable standards. Thirdly, by no means do all children who are abused become criminals.** They suffer and have problems, but they do not necessarily turn to crime. There is yet another dimension to be considered. **Unless one has an antisocial youngster of his own, it is almost impossible to grasp what life is like in such a family. The future criminal may turn home life into a never-ending nightmare.** He steals from parents and siblings. From an early age, he resists authority. The simplest request may result in a battle. He sneaks around or blatantly defies his parents at every turn. Such a youngster ferrets out and exploits any weakness or vulnerability in family members. Whatever friction naturally exists among family members, he exacerbates. The parents are constantly anxious, for whenever the phone or doorbell rings, they wonder if it is a complaining neighbor, a frustrated school official, the police, or even a hospital official telling them that their child is dead. Living in such fear and turmoil destroys family life. It is not unlikely that a besieged parent will react with physical punishment only to have the child threaten to report child abuse. Thus, those who blame parents for their offspring's criminality totally ignore the child's role in creating the problems. They see the child as a victim rather than a cause of family problems.

Some crimes are thought to have been committed by individuals suffering from mental illness and, therefore, these individuals are not responsible for the results. **Yochelson and Samenow hypothesize that the insanity defense is often a charade participated in by criminals wanting to avoid long prison terms, by well-meaning mental health professionals, and by the courts.** Criminals are often adept at "feeding" psychiatrists and others what they believe these professionals want to hear. Recognizing that insanity is a passport out of prison, their malingering is limited only by their imaginations. Unsophisticated "street" criminals have been successful convincing others that they were insane at the time the particular crime was committed. Regarded as mentally ill and admitted to a psychiatric hospital, all they need do is continue to play the game and convince others that they have been rehabilitated so they can eventually be discharged.

Yochelson and Samenow found that **there are a small number of criminals who go through alternating phases of psychosis and crime. They may be psychotic following a crime, but interviewers erroneously conclude they were psychotic before committing the crime. When psychotic, these individuals are too confused to commit an organized crime. Furthermore, the thought content of the psychosis is often anticrime, even religious in nature.** A person can, however, be both psychotic and a criminal, but one condition does not cause the other. By analogy, one can have cancer and heart disease, but these are separate disease entities. It is necessary to ask the proper questions in order to determine that, even though psychotic, the person who committed the crime was still free to make a choice. When the criminal is in legal jeopardy, however, he is not likely to acknowledge this unless approached by a very skilled interviewer. Although there may be cases in which a crime is committed by a person who is not responsible, to date neither Samenow nor Yochelson have found this to be true.

Causation: Still an Enigma

If a person does not become a criminal due to external circumstances; if his criminality is not a product of his upbringing; if his crime is not a product of a mental illness, **what then is the etiology of criminal behavior? A genetic explanation remains. Although some findings support such an explanation, these are regarded as preliminary and questioned by researchers.** Yochelson and Samenow, who also conducted physical studies (e.g., blood, EEG, XYY chromosome), remained unable to explain why people become criminals. They abandoned the search for causes for two reasons: **no factor or set of factors that they explored turned out to be necessary or sufficient to explain why a person becomes a criminal**. Furthermore, they discovered that criminals used the search for "reasons why" to further explain and justify their criminality. One criminal said in a moment of candor, "If I didn't have excuses for crime before psychiatry, I certainly have enough now." Instead of focusing on why these people were criminals, the approach was to study their thinking processes.

The Concept of The Criminal Personality

Yochelson and Samenow conducted a phenomenological study in which they found it necessary to see the world from the criminal's point of view. Behavior is largely a product of thinking, and it was the criminal's thought patterns that became their focus. There are thinking patterns common to all criminals, whatever their background or their particular criminal pattern.

Critics of Yochelson and Samenow have pointed out that there is no such entity as a criminal personality. They correctly observe that what constitutes a criminal act changes with the times. But there are people who, regardless of their society, will run afoul of the laws and mores. In other words, for life to be personally exciting is to do the forbidden, whatever the forbidden happens to be. This view is expressed by one man who declared, "If rape were legalized today, I wouldn't rape, but I'd so something else."

Like other issues, **criminality lies along a continuum.** If one were to speak of criminal acts, the continuum might range from a minor traffic offense to mass murder. But Yochelson and Samenow did not speak in terms of criminal acts, whose definitions may be different from jurisdiction to jurisdiction or from one era to another. Rather **they spoke in terms of thinking patterns which also lie along a continuum.** Their approach was not unlike that of Alfred Adler who in 1930 stated that he was not looking into crimes but rather into individual lives.[5] In their phenomenological study, Yochelson and Samenow found that **the thinking patterns of criminals also lie along a continuum.** Perhaps there is larceny in every soul. Certainly, each person at some point in his life has been irresponsible. Thus, the thinking patterns of the criminal are shared, to an extent, by people who are not criminals. In the career criminal, all the patterns are present to an extreme. The whole, then, is more than the sum of the parts. **The career criminal *thinks differently* from the responsible person.**

The Criminal's View of Himself and the World

From an early age, the criminal is dissatisfied with the life that his responsible peers are living. He views the world as a chessboard with people and objects for him to use in serving his own ends. Human relationships serve as avenues for conquests and triumphs. He pursues power and control for their own sake. For him, becoming a success is to become important overnight. It is not the step-by-step process of working toward, and then achieving, a goal. If entrusted with power and legitimate control over others, that is not enough. **To be somebody, he wants to do the forbidden--to take risks that others won't.** Because he lies so often to get what he wants, others think he has become a "compulsive" liar unable to tell the truth. Herein lies another myth. If one understands the criminal, he recognizes that lying serves a purpose beyond that of covering his tracks and avoiding punishment. By lying, the criminal preserves a view of himself and the world. There is **power in lying**, in believing that he has "pulled the wool" over the eyes of others.

The responsible person tells a an occasional white lie. He does so to avoid embarrassment, to protect others from bad news, or to cover up wrongdoing; but lying does not become a way of life. The criminal will say that he rode in a white car when it was blue. He is at the extreme end of the continuum wherein lying does become a way of life. Yet, there is nothing compulsory about it, for he can tell the truth if he believes it will serve his purpose.

Although he may be of average intellectual potential, the criminal is a concrete thinking. On an intelligence test, **he may be able to abstract. He may appear highly conceptual as he philosophizes about matters remote from him. However, the concepts of responsible living that most of us learn early in the primary grade years, he never acquires for they are antithetical to his way of life.** Ask a religiously observant criminal what he means by "religious" and, almost invariably, he will respond in terms of the act of going to church, reading the Bible, or celebrating a holy day. For him, religion is not an operational guide to life, to dealing with his fellow man. Essentially, **the criminal never develops a concept of a person.** Human beings are mere instruments to use as he pleases. Even his mother who stands by him, who bails him out of difficulty, and who provides for him is never seen as a person in her own right. She is here to serve him.

That the criminal is concrete in his thinking also means **he does not develop a concept of injury to others. He does not think of himself as victimizing others. Rather, he is the victim when others interfere with his objectives.** His idea of injury is as literal as leaving a person in a pool of blood. Asked to explain what the victim suffered, he will either say nothing or respond superficially in an attempt to please his questioner.

The criminal is **so changeable** that others who are perplexed by this feature regard it as a sign of mental illness. **He may be charming, helpful, and considerate in the morning and a complete tyrant in the afternoon.** With great sincerity, he may tell others that he wants to change and be more responsible. Yet, within twenty-four hours, he commits a terrible crime. **Although changeable, he is able to choose**

what he wants. He is not simply at the mercy of uncontrollable inner forces.

The criminal is a fearful person, **but he does not want to show fear. He has the remarkable capacity to shut off fears, of getting caught and of conscience, long enough to do as he pleases.** To put it more graphically, he can change from tearfulness to brutality within minutes.

A great deal of what the criminal does seems impulsive and senseless to observers, yet **there is nothing impulsive about the criminal's behavior. He knows what he wants and does whatever he thinks necessary to get it.** If he spots an opportunity for excitement and personal gain, he will strike in an instant. He becomes so proficient in committing crimes that he often does so without prior planning. Invariably, however, he knows exactly what he is doing. A crime that appears without motive has a hidden motive. It is the criminal's attempt to build himself up at the expense of others.

Some crimes are so bizarre and morbid that experts conclude these could only be the product of a sick mind. Yet, the criminal knows right from wrong, and he knows the occupational hazards of crime--getting caught, convicted, confined, injured, or even killed--but he can shut this off long enough to do as he pleases. **To kill and mutilate the body of a stranger is not "normal." However, to say it is a "sick" act reveals more about the reaction of the observer than about the mind of the criminal.** The killer gets a "high" reducing a person to a quivering, pleading speck of humanity and then destroying him. The act itself is the product of a deliberate, calculating mind.

No matter how many crimes he has committed, no matter how

brutal and diverse they are, each criminal regards himself as a decent human being. In several ways, the criminal maintains the view that he is, at heart, a good person. First, he knows he has done kind deeds and others think well of him. (There are people who hold him in high esteem and know nothing of his criminality.) Second, he has talents and skills for which he has been recognized. (There is much artistic and musical talent behind bars.) Third, his aspirations for a good life fortify his view of his personal goodness. Perhaps, most important, he knows he has broken the law but, in his view, he has only done that which he needed to do to fulfill his own objectives. His intentions remained good. As one man said, "If I thought of myself as evil, I couldn't live."

There are many other thinking patterns characteristic of the person who has made crime a way of life. One is that he has **no concept of interdependence.** Put nine criminals on a baseball team, and each considers himself the captain. A second is **the pattern of deferring or eventually defaulting on whatever is not to his liking or interest.** Much about a responsible life the criminal considers intolerably boring. Thus, he simply does not bother. Promises are broken, bills go unpaid, obligations are unrecognized. Another characteristic of the criminal is **his unrealistic expectations of the world**. Thinking something, he is positive it will happen. Without fact-finding, he makes assumptions about the world which he then expects to operate on his terms.

There are numerous other criminal thinking patterns. One that pervades the criminal's daily existence is **fear of being "put down." The criminal has a "thin skin." He can "dish out" anything, but will not take even the slightest criticism.** If one expected the world to always operate on his terms, the number of threats to that world view would near infinity. Because he thinks in extremes, it takes little to threaten his unrealistically inflated self-concept. When even a tiny detail of life does not go according to plan, it is as though his entire self-concept is on the line. The criminal is constantly warding off the most trifling of inconveniences. **Thus, he is an angry individual most of the time, even if he does not show anger.** When he feels threatened, the perceived threat is global. Rather than be reduced, he wants to show he is somebody. To gain control of a situation or of another person, he will retaliate by stealth or force.

Perhaps readers of this account of criminal thinking patterns will argue that **there are people who show aspects of these patterns who are not criminals.** This is not the issue. **When one understands the criminal's mental processes, one finds that these and other thinking patterns are integral parts. He is extreme in these features.** In that they inevitably lead to criminal behavior and injury to others, they are all errors in thinking. If the criminal is to change, the errors of thinking must be addressed.

Helping the Criminal Change: Motivation

Many professionals in correctional facilities, mental health, social services, other segments of the criminal justice system and in society at large believe criminals do not change and cannot change. Billions of dollars have been channeled into rehabilitation programs with few positive results. Yet the concept of "rehabilitation" as applied to the criminal personality is a misconception and a misnomer. To "rehabilitate" means to restore to an earlier constructive state or condition. Offender rehabilitative measures have included providing educational opportunities, job skills, social skills, counseling, and therapy. This resulted in criminals who have education, job skills, social skills, and occasional personal insights. They remained, however, criminals.

The rehabilitative measures were well-conceived and somewhat useful, but they did not touch the core of the criminal–the way he thinks. Thus, the scope of the task is broader than "rehabilitation." Rather, it is to "habilitate" the criminal or help him change the way he thinks. **Psychotherapeutic and counseling approaches successful with a variety of client populations have not been successful with criminals as they constitute a very different group.** What is necessary is to know who the criminal is and how he thinks. Then it becomes possible to approach him more realistically in terms of making decisions and developing an approach to help him become a responsible human being.

There are only two effective sources of motivation to change long-standing patterns: external and internal. For a criminal to make significant and enduring change, there must be leverage from the outside. This does not imply that change can be or should be coerced. Rather, **life provides consequences for ongoing, irresponsible, or illegal behavior.** Some criminals can be worked with in the community if they are on probation or parole. Work can begin in the institution if there is inducement. **The most important part of the process of change, however, is to help the criminal see himself as he is and to reject his criminal behaviors.** None of us changes anything about ourselves unless we become disgusted with certain behaviors. How then is this accomplished with the criminal who sees himself as above others and who is reluctant to give up an exciting way of life for one that he has renounced?

Overview of the Habilitative Process

Essential to the process of change is a wide-open channel with three components; **full disclosure, receptivity, and constructive self-criticism.** The criminal, however, opens and closes the channel to suit his own purposes. The method by which an increasingly open channel is created is one of phenomenological reporting. This requires the criminal to report whatever he is thinking. It is similar to obtaining a computer printout of the mind, without explanation, addition, subtraction, or tailoring the report.

Even though the criminal is unlikely to fully disclose his thoughts at the outset, almost every time he opens his mouth, an error in thinking becomes evident. It is the change agent's task to **point out errors of thinking, define them, and help the criminal see the role these have played in his life. Especially important is the injury the criminal has inflicted on others, even those about whom he says he cares.** A thought or afterthought can provide a theme for a discussion about a life pattern. The objective is to **proceed from the concrete to the conceptual.** It is the incipient thought of today that leads to the crime of tomorrow.

This approach goes beyond other rational/cognitive treatment approaches. It requires more than rational problem solving. Most rehabilitation counselors and therapists have probably had the frustrating experience of believing their client had gained insight into a problem, only to have the client fail to apply the insight to a similar event later.

Yochelson and Samenow recognize that **this concrete thinker will remain so unless an error in thinking is developed as a concept and then related to life--past, present, and future.**

In such an approach, there is virtually **no emphasis on feelings. Rather, the approach is that when thinking changes, feelings also change. The stance taken toward anger is vastly different from that in traditional psychotherapy. The criminal is encouraged first to control the anger, not express it. In turn, he finds that as his thinking about himself and the world becomes more realistic and responsible, he feels less anger. The objective is to get as close to eliminating anger as possible.** Anger in the criminal should be avoided in the same way that the first sip of alcoholic punch should be avoided by the alcoholic.

Initially, the motivation for change is all negative--fear of external consequences and the client's increasing loathing for the kind of person that he is. **As the client practices the correctives of thinking errors, however, he finds that positive things occur.** He does not have to continually look over his shoulder for the police and others who want to hold him accountable. He has a sense of "being clean." People he has admired and those who have wanted to trust him start to regard him in a new way. And, finally, he has accomplished things he does not want to jeopardize by returning to old patterns.

The process is not quick, simple, or infallible. There are many cycles in the change process. Many offenders drop out or try to play "both sides of the street," inevitably returning to crime. However, it is possible to work with some people either in the community or in the institution who are fed up with the kind of life they have been leading. It is mandatory that if this habilitative work is started with an inmate while he is confined that there be a follow-up when he returns to the community.

The Criminal Personality in Perspective

Contemporary work on the criminal personality has been available to professionals since 1977. Throughout the country, there have been community and institutional programs that have adapted this work to their own settings. The controversy as to whether there is a criminal personality has largely abated as people have endeavored to determine how the concept can be most helpful to them in their work with offenders.

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QUESTIONS BASED ON THIS LESSON

37. Which of the following themes seems to characterize the thinking pattern of the career criminal?

A. Placing value on human relationships, with a reluctance to use people for self-serving purposes

B. The desire to be a success (in his terms) overnight, without the step-by-step process of working toward goals

C. A reluctance to take risks

D. A highly developed self concept

38. According to Dr. Samenow, the career criminal:

A. Does not seem to have developed a concept of the meaning of injury to others

B. Acts largely out of impulse and is never guided by a plan of action

C. Is usually cheerful, affable, and without mood changes

D. Considers himself to be suffering with a mental or emotional malady

39. According to the author, the most important strategy in offender habilitation is:

A. Severe and harsh punishment

B. Long-term, in-depth psychoanalysis

C. Reeducation aimed at motivating the client to see himself as he has been and is, and, rejecting this, to strive for a different self-image and way of thinking

D. A gentle, permissive penal code

over, please...

40. Psychotherapy with the career offender:

A. Differs little from ordinary psychotherapy, and calls for consistent empathy with the client

B. Emphasizes thinking more than feeling, and the control of anger rather than its expression

C. Is most effective when the client has no fear of the consequences of his aberrant behavior

D. Usually involves adjunctive pharmacotherapy

Directions in
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VOLUME 1 • LESSON 11

Creativity and Mental Illness

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EDITOR'S NOTE

What is the relationship between creativity and mental health? Historically, issues surrounding the relationship have been replete with controversy. According to Dr. Storr, there have been two opposing schools of thought. One school views the creative genius as unstable and prone to neurosis or psychotic breakdown. In contrast, others perceive the creative individual as having an exceptionally well-balanced personality and possessing noble attributes. Answers to the controversy may well be an individualistic matter, depending upon one's definitions of creativity, mental health, and mental illness.

Could the creative process, encompassing synthesis and reintegration, also be an essential part of an individual client's rehabilitation process? If there is a relationship, then creativity may impact the course of many rehabilitative activities, including psychotherapy, psychological testing, occupational therapy, and vocational rehabilitation. One biographical illustration offered by the author with particular relevance to rehabilitation is that of Beethoven. Not only did Beethoven evidence mental illness, but he was also sensorially and physically impaired. Using modern rehabilitation standards, he would be diagnosed as multiply disabled.

Psychological testing suggests a high correlation between ego strength and creativity, as well as between creativity and those traits on the Minnesota Multiphasic Personality Inventory (MMPI) predictive of a high rate of recovery from emotional disorder. Characteristics of the creative temperament include independence, an adequate level of intelligence, an appreciation of humor, the ability to question presumptions, and an integration of what has traditionally been viewed as masculine and feminine traits.

Nevertheless, there is also evidence that certain creative personalities (e.g., creative writers) show a high incidence of pathological traits on the MMPI. The author suggests that in some instances the craetive capacity may be a critical form of adaptation, serving to protect the individual from being overwhelmed by potential pathology and enabling a synthesizing, healing process. Certainly, when otherwise-creative individuals suffer with mental illness, the quality of their productivity appears significantly diminished.

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Definition

Creativity can be defined simply and concisely as "the ability to bring something new into existence."[1] In this context, mental illness includes neurosis and personality disorders as well as the major psychoses. In all cultures, it is recognized that, in the arts or the sciences, few people are capable of original contributions. The psychology of such people is, therefore, of exceptional interest and has been the subject of considerable controversy as well as of a variety of studies by psychologists and psychiatrists.

Historical Background

The idea that creativity and mental illness are in some way linked dates back to classical times. Montaigne, who was fond of quoting classical writers, states in one of his essays:

> And so the poet is often rapt in admiration of his own work, no longer recognizing the track along which he ran so fine a race; in him also we call it madness and frenzy. And as Plato says that in vain does a sober-minded man knock at the door of poetry, so Aristotle says that no mind of any eminence is free from a tinge of madness. And he is right in calling madness every transport, however admirable, that transcends our reason and judgment; seeing that wisdom is a well-ordered government of our soul, carried out with measure and proportion, for which she is responsible to herself.
>
> Plato argues thus: "that the power of prophecy is above us; that we must be beside ourselves when we exercise it: our sober sense must be clouded either by sleep or by some malady, or lifted from its place in a heavenly rapture."[2]

In this passage, Montaigne, who was an eminently reasonable man, illustrates a confusion that has dogged discussion of the relationship between mental illness and creativity through the centuries. If "every transport, however admirable, that transcends our reason and judgment" is to be called madness, then inspiration is a form of madness, and so are dreams and some types of fantasy.

Montaigne failed to distinguish between the incursion into consciousness of what we would now call derivatives of the unconscious, or "unconscious material," and the overthrow of reason by sustained mental illness. Dreams have often been compared to psychosis, but it is only when something like dream experience persists, becomes confused with ordinary waking experience, and distorts perception of reality when the subject is awake that we call the person psychotic. Moreover, although wisdom may, in Montaigne's words, be a "well-ordered government of our soul," **modern thinking (especially since the time of Freud) has recognized that even the best-controlled and wisest thinkers are far more influenced by irrational, "unconscious" factors than was once supposed.** It has even been suggested that various systems of philosophy, advanced by the most gifted and profound thinkers, are no more than highly elaborate rationalizations of the irrational prejudices and assumptions of each philosopher.

It is important to realize that **access to the unconscious and, therefore, to irrational sources of inspiration, is not the same as being overwhelmed by the unconscious,** which is what Jung described as happening in cases of schizophrenia. The Greeks and Romans recognized this. The Greek word "psyche" and the Latin word "genius" are closely equivalent. In fact, both concepts are very similar to our modern notion of "the unconscious." The Greeks and Romans recognized the necessity of postulating that there was a part of the mind or an indwelling spirit that was different from, and independent of, conscious reasoning and yet capable of influencing thought and action. Their ideas of what we now term "the unconscious" are in fact closer to those of Jung than to those of Freud. Although Freud did acknowledge that the unconscious played a part in creative activity, he thought of it predominantly as containing unacceptable material that had been repressed. Jung, on the other hand, thought of the unconscious as prior to consciousness and as a source of inspiration.

Throughout history, there have been two opposing schools of thought about the relationship of creativity and mental instability. One view commonly held in the 17th and 18th centuries regarded the genius as a person of nobility of heart, delicacy of feeling, and exquisite sensibility, and affirmed that great and beautiful works could be produced only by well-balanced, upright characters. Men of genius were considered better endowed than, but not different in kind from, the ordinary man--usually gifted but in no way pathological. Dr. Johnson maintained that "the true genius is a mind of large general powers, accidentally determined to some particular direction."[3] "I am persuaded," he said, "that had Sir Isaac Newton applied to poetry he would have made a very fine epick poem. I could as easily apply to law as to tragick poetry."[4]

Willpower, effort, and application were what counted, rather than inspiration. The historian Thomas Carlyle referred to "'genius', (which means transcendent capacity of taking trouble, first of all),"[5] and the painter Hogarth stated: "I know of no such thing as genius, genius is nothing but labour and diligence."[6] In his book *Hereditary Genius*, written in 1869, Francis Galton disparages the notion that genius is "a sense of inspiration" and attributes creative achievement to "ability," "zeal," and "a capacity for hard work."[7]

At the opposite extreme is the "romantic" view that creative

geniuses are necessarily unstable and particularly liable to neurosis or psychotic breakdown. Supporters of this idea point to such men of genius as Van Gogh, Strindberg, Newton, Schumann, Pound, Kafka, and Nietzsche–all of whom at times exhibited psychotic or near-psychotic symptoms. The view that mental illness and creativity go hand in hand is further supported by the number of creative people who have taken their own lives–among them Ernest Hemingway, John Berryman, Sylvia Plath, and Virginia Woolf.

Is it possible to reconcile these opposing points of view, both of which seem to have something to be said for them? I think it is and, in the following pages, will indicate how this can be achieved.

Objective Studies

In 1940, Havelock Ellis, known for his *Studies in the Psychology of Sex*, published the book, *A Study of British Genius*. This was based on the British Dictionary of National Biography, from which he selected the names of 975 men and 55 women. **Among these eminent people, Ellis could discover only 44 (4.2%) who were demonstrably insane.** He was obviously disappointed by this figure and concludes: "The association between genius and insanity is not, I believe, without significance, but in face of the fact that its occurrence is only demonstrable in less than five per cent of cases, we must put out of court any theory as to genius being a form of insanity."

What Ellis' figures show is that **mental illness is less likely to occur among the educated and successful–a finding confirmed by later research, which shows a higher incidence of mental illness among lower social classes.**

L. S. Terman, who examined the development of more than 1300 intellectually superior subjects from childhood on, demonstrated that the **physique, health, and mental ability of those with IQs of 135 and over are better than average. He also showed that success in adult life is usually associated with emotional stability** and the absence of obvious conflicts, although this was not invariable.[9]

Surveying the lives of eminent scientists, Cattell and Butcher state:

> **The typical research scientist of genius appears introverted and stable**...One must agree with Terman that, among scientists at least, the average level of ego strength and emotional stability is noticeably higher among creative geniuses than in the general population, though it is possibly lower than among men of comparable intelligence and education who go into administrative and similar positions. **High anxiety and excitability appear common** (e.g. Priestley, Darwin, Kepler), **but full-blown neurosis is quite rare.**[10]

Cattell and Butcher go on to assert that creative artists show much more instability than scientists, but they do not quote any figures to support this assertion.

Temperamental Differences

There is some evidence to suggest that those who choose to study the experimental, "hard" sciences differ in personality from those who are attracted to the humanities. Liam Hudson[11,12] has distinguished two varieties of person, whom he names "convergers" and "divergers." **Convergers** do well in conventional intelligence tests; specialize in physical sciences or classics; hold conventional attitudes; prefer technical, mechanical interests in their spare time; do not easily recall their dreams; and are emotionally inhibited. **Divergers** do well in open-ended tests (in which there is no single right answer); specialize in the arts or in biology; express unconventional attitudes; have interests that are connected more with people than with things; are able to recall their dreams; and are emotionally uninhibited. All developing children have to learn control over their emotions and their immediate impulses. **It appears that convergers learn control at an earlier stage in their emotional development than divergers,** and that this is one factor shaping adult development.

If, as Cattell and Butcher say, scientists are more stable than those working in the arts and humanities, this difference may be part of the explanation. **However, the early development of control can sometimes lead to loss of flexibility. It is noteworthy that, for the most part, creative physicists and mathematicians make their major discoveries early in life (e.g., Newton and Einstein), whereas creative painters, musicians, and writers continue to change and develop throughout their lives and may even take new directions in old age (e.g., Verdi).**

Ego Strength

Ego strength can be briefly defined as "personal effectiveness." **Tests of ego strength include the measurement of such traits as dominance, self-acceptance, responsibility, self-control, tolerance, and intellectual efficiency. The California Psychological Inventory, developed by Harrison Gough and designed to measure such traits, shows that creative people score higher than those who are less creative. A selection of items from the Minnesota Multiphasic Personality Inventory, originally chosen to predict the likelihood of recovery from neurosis, proved a good measure of ego strength.**

Creative writers obtain superior scores on this test also.[13]

One aspect of ego strength is the ability to tolerate conflict and its accompanying anxiety. In one of his letters, the poet Keats says that the man of achievement in literature must possess the quality of "Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts without any irritable reaching after fact and reason."[14] The Barron-Welsh Art Scale, which presents subjects with a set of 62 abstract line drawings ranging from the simple and symmetrical to the complex and asymmetrical, shows that **creative painters and architects show a marked preference for the complex and asymmetrical.**

> If one considers the meaning of these preferences, it is clear that **creative architects are especially disposed to admit complexity and disorder into their perceptions without being made anxious by the chaos.** They appear to have both a strong need and a superior capacity to achieve the most difficult and far-reaching ordering of the richness they are willing to experience.[15]

Independence

Most authorities who have studied creative people agree that **independence is a notable characteristic. This shows itself particularly in the fact that they are much more influenced by their own inner standards than by those of their profession or society.** In the study of architects referred to previously, the subjects were divided into three groups according to their creativity. The most creative group was concerned primarily with meeting personal standards of artistic excellence; the least creative with simply conforming to standards of the architectural profession. **The independence of the highly creative was also evidenced in that they belonged to fewer organizations, professional associations, and social groups than did their less**

creative peers. Creative people need periods of solitude for contemplation. They are often unwilling to reveal their ideas to others at an early stage of development, for fear of their ideas being damaged by premature criticism or lack of comprehension by the less gifted or envious.

Skepticism

In order to achieve anything new, the creative person must be able to question what has gone before. Ordinary people are content to accept what their teachers tell them; the creative person takes nothing on trust. This is particularly obvious in the case of the experimental sciences. New discoveries lead not only to being able to account for a wider range of phenomena than could be accounted for previously, but also to discarding what had previously been accepted. Only those who are skeptical enough to doubt the findings of their predecessors are mentally prepared to notice anomalies that suggest the inadequacies of previous theories. In one of the four addresses that Ernest Jones gave in 1956 to celebrate the centenary of Sigmund Freud's birth, he selected skepticism as one necessary characteristic of genius.

> He must have refused to acquiesce in certain previously accepted conclusions. This argues a kind of imperviousness to the opinions of others, notably of authorities. Furthermore, he often has the capacity of seeing the existence of a problem where others have passed it by; he has refused to take something for granted as being either without meaning or too insignificant to bother about. This aloofness sets him free to speculate and investigate.[16]

Love of Truth

In the same address--"The Nature of Genius"--Ernest Jones quotes Goethe's remark that "the first and last task required of genius is love of truth." While Goethe's formulation is inadequate, since there are many other facets to genius, it is certainly true that creative persons, both in the sciences and in the arts, are deeply concerned with discovering the truth or with portraying the truth of their own experience. **The "eureka" experience of having arrived at a new and truthful insight, whether this is a discovery about how the external world works or about the meaning of one's own subjective experience, is exhilarating. It is usually accompanied by an increase in the sense of mastery--of power over some aspects of outer or inner reality.** There is reason to believe that creative persons are strongly motivated by the need to master what they perceive as disordered or chaotic, and that they obtain intense satisfaction in achieving this end.

Intelligence

It is obvious that **most creative work requires intelligence, but there is little correlation between creativity and the highest ranges of IQ.** A man with an IQ of 160 may be less productive and less original than a man with an IQ of 130. Most of us have encountered highly intelligent individuals who, in youth, gained high marks in all their examinations but never subsequently achieved anything remarkable. Getzels and Jackson[17] differentiated two groups of gifted adolescents: the highly intelligent and the highly creative. The two groups were then asked to rank the qualities in which they would have liked to be outstanding, such as "emotional stability" or "wide range of interests." It is significant that **the highly creative put "sense of humor" near the top, while the highly intelligent ranked "sense of humor" last.**

Creative ability and play are closely related, in that playing around with ideas and fantasies may lead to creative innovation that the sober use of directed thinking cannot reach. Wallach and Kogan extended Getzels and Jackson's work to discover four categories of children: those with high creativity and high intelligence; those with high creativity and low intelligence; those with low creativity and high intelligence; and those with low creativity and low intelligence.[16] Their work confirms the finding that, although a certain degree of intelligence is required to engage in the areas in which creativity is possible, creativity itself is something different from the kind of intelligence measured by conventional intelligence tests.

Masculine/Feminine Balance

Thus far, the studies quoted seem to confirm the first view outlined above: that the creative person is simply healthier, more gifted, more effective, and better balanced than the average person. However, this is not the whole story. **D. W. MacKinnon, in the work already quoted,[15] notes that all his architects and all the other highly creative male groups that he studied scored particularly high on the femininity scale as measured by the Minnesota Multiphasic Personality Inventory.** MacKinnon writes:

> The more creative the architect, the more he reveals an openness to his own feelings and emotions, a sensitive intellect and understanding self-awareness, and the wide-ranging interests including many which in the American culture are thought of as feminine. In the realm of sexual identifications and interests, our creative subjects appear to give more expression to the feminine side of their nature than do less creative persons. **If one were to cast this into Jungian terms, one would say that these creative persons are not so completely identified with their masculine persona roles as to blind themselves to or deny expression to the more feminine traits of the anima.** For some of the

> balance between masculine and feminine traits, interests and identifications is a precarious one, and for several it would appear that their presently achieved reconciliation of these opposites of their nature has been barely achieved and only after considerable psychic stress and turmoil.[15]

Psychopathology

Other studies have shown that creative people, in spite of the positive features already listed, possess more psychopathological traits than the average person. "Distinguished writers score particularly high on scales measuring schizoid, depressive, hysterical and psychopathic tendencies on the MMPI. They are also well above the general population norm in terms of femininity of interest pattern."[13] A study of writers conducted in 1975 at the University of Iowa Writers Workshop found a high incidence of psychiatric symptoms, illness, and treatment in a group of poets and novelists.[19]

It may be tentatively concluded that creative people appear to be more psychiatrically disturbed than the average person, but they are also equipped with greater resources than the average person to deal with their conflicts and problems.

This conclusion jibes well with the discrepancy between creativity and intelligence that has already been noted. It is clear that highly intelligent people who are not creative are not motivated to be so. Perhaps the motivation to be creative springs from internal conflicts that are lacking in the uncreative, however intelligent they may be. It makes sense to suppose that the world's greatest men of genius are more liable to psychiatric disturbance than the average person but also better at coping with their internal conflicts by means of their creativity. If this is the case, it goes some way toward resolving the problem with which this lesson started: the two opposing views concerning men and women of genius. If such people are equipped with both more psychopathology and healthier traits than average persons, one would expect that there would be two opposite and alternating points of view.

Adaptability

If this hypothesis is accepted, certain conclusions follow. First, **the ability to create must in some sense protect the creator against being overwhelmed by his psychopathology.** Second, **if his creative powers desert him, it might be expected that he would more overtly suffer from his psychopathology, whether or not he has an actual breakdown.** Third, **creative discovery relating to the external world must in some sense be matched by what is going on in the inner world of the creator.** That is, **the production of a work of art or a new scientific hypothesis must be related symbolically to synthesizing, healing processes going on within the psyche of the creator.** Otherwise, he would not be protected against his conflicts or experience the deep satisfaction (e.g., the "eureka" experience) that creative achievement brings.

Biographical Illustrations

What follows is necessarily anecdotal. Not enough objective studies have been carried out in this complex field for scientific certainty to have been attained. However, **examination of the lives of several great creative men of genius strongly suggests that the conclusions referred to are correct.**

My first example is **Franz Kafka,** generally acknowledged to be one of the greatest creative writers of the 20th century. Kafka is sometimes portrayed as the archetypal alienated man. **His writings convey a terrifying picture of helplessness in a world in which arbitrary power is exercised upon victims who neither deserve nor comprehend their fate.** Kafka's world is like that of the concentration camp. Since he died in 1924, however, what he depicted was his own inner world, without reference to the horrors that were still to come in Nazi Germany. **Although Kafka was not psychotic, the world he depicted closely resembles some aspects of schizophrenic experience.** I believe, though I cannot prove, that his writing preserved him from psychotic breakdown.

Kafka was born in Prague on July 3, 1883, to a Jewish family. His father was a big, heavy, dogmatic, hearty bully who was subject to terrifying fits of rage. Soon after Franz's birth, his mother left him in the care of a nurse, because his father demanded that she return and help him in his shop. Franz never saw enough of his mother, never became reconciled to her absence, and also suffered from changes of nurse. In addition, **his childhood was unsettled** by five moves of home and by the deaths in infancy of his two younger brothers. **He grew up exhibiting almost every feature of the psychopathology we call schizoid.** He suffered from a profound, inescapable sense of **guilt**; severe **hypochondria; his doubts about his own identity,** and **alienation from his body.** Intermittently, he experienced **depersonalization** and **derealization.** He was plagued with **sadomasochistic fantasies,** which find terrifying expression in his writings. He suffered from the typical schizoid dilemma of **a desperate need for love combined with an equally desperate fear of close involvement.** He had a relationship with a girl (to whom he was twice engaged) that lasted five years, but his fear of actual proximity was so great that the relationship was conducted almost entirely in letters. The chief themes of his writings are guilt, punishment, helplessness and the impenetrability and unpredictability of authority.

Kafka perfectly illustrates one way of coping with the schizoid fear of close involvement with others. Through his writing, he could objectify his inner world, win recognition and acceptance, and yet continue to keep other people at a distance. Writing, for him, was also a way of survival, and I agree with Erich Heller, who writes: "Of course this is a disposition akin to madness, separated only from it by a writing table, an imagination capable of holding together what appears to have an irresistible tendency to fall apart, and an intelligence of supreme integrity."[20]

My next example, **Isaac Newton, suffered from overt mental illness. It is likely, though not certain, that the collapse of his defenses came about because his creative powers were declining.** Physical factors may also have played a part in his illness.

Newton was born, prematurely, on Christmas Day, 1642. His father had died three months before his birth. Thus, during his early infancy, the puny boy had his mother's undivided attention. **Just after Newton's third birthday, his mother not only remarried but also moved to another house, leaving the child in the care of his maternal grandmother. We know, from his own notebooks, that Newton never forgave this betrayal.** In a confessional list of his sins, he blamed himself for having wished to burn down the house belonging to his mother and stepfather. **Newton grew up to be an eccentric recluse--**

solitary, suspicious, quarrelsome, and so entirely devoted to work that he often forgot to eat. He never married or, so far as is known, had sexual relations with anyone. He was anxious, hypochondriacal, and self-punitive. His adult character was composed of a mixture of depressive and paranoid traits. He feared the influence of others upon his work, and failed to make due acknowledgement to his predecessors. Like most physicists and mathematicians. Newton made his most important discoveries when he was very young–in his early 20s. **But he was so reluctant to publish that when he discovered the law of universal gravitation, he said nothing about it to anybody.**

In 1693, Newton became so disturbed in mind that rumors about his insanity spread through Europe. His mental illness was preceded, as many such illnesses are, by loss of appetite and insomnia. Newton broke with his friends Pepys and Locke, and accused the latter of trying to embroil him with women. **His illness, occurring as it did around his 50th birthday, seems to have been a midlife depression with paranoid features. The details are not known, but Newton made a good recovery within about 18 months.** Two and a half years later, he was appointed Warden, and then Master, of the Mint. He left Cambridge for London and, like many scientists, abandoned research for administration. One of his biographers writes: **"Newton's crisis was followed by a dramatic reorganization of his personality and a rechanneling of his capacities that enabled him to manage his existence successfully for more than three decades."**[21] It seems highly probable that this reorganization was forced upon Newton by the decline of the creative forces that had kept mental illness at bay until his midlife crisis. His ego strength enabled him to channel his drives in new directions.

My final example is concerned with demonstrating that the production of a work of art is symbolically related to integrating processes going on within the mind of the creative artist. One of the most powerful pieces of music ever created is the so-called "Grosse Fuge," which Beethoven intended as the last movement of his late-period quartet in B-flat, opus 133. The music critic Martin Cooper writes: "What grips the listener is the dramatic experience of forcing--for there is frequently a sense of violence in his mastery--two themes which have, by nature, nothing in common, to breed and produce a race of giants, episodes or variations that have no parallel in musical history."[22] We cannot now be certain about what Beethoven felt upon completing this remarkable work, but some critics have labeled one theme as representing necessity and the other as representing free will. We know that **Beethoven was both aggressive and rebellious. His deafness and recurrent illnesses imposed severe limitations upon him** that he must have resented as restrictive. Listening to his music, one marvels that such forcefulness can be contained and sublimated into making a new and extraordinary synthesis. One biographer of Beethoven refers to the coda of the "Grosse Fuge" as giving a "feeling of sunshine after storm."[23] Who can doubt that such music is intimately bound up with the personal emotions and conflicts of the composer? **Although Beethoven was a disturbed character who came from a difficult background and also had to fight against the worst disability that can afflict a musician, he never became mentally ill. His marvelous creative powers both protected him and enabled him to integrate the violent emotions that, at times, must nearly have torn him asunder.**

Summary

Although creativity may be powered and motivated by conflicts and tensions within the psyche of the creator, the creative process itself is essentially healthy, positive and life enhancing. If the artist's defenses crumble and he becomes overtly mentally ill, his creative powers decline. This is true of both depressive and schizophrenic types of mental illness. When artists become psychotic, they generally show deterioration in their work or cease production altogether. At the onset of a schizophrenic illness, the strangeness of his experience may stimulate an artist to record something of his new way of perceiving the world. However, as the Dutch psychiatrist J. H. Plokker wrote:

> **Everyone who knows anything about art sees the difference between the normal and pathological when he looks at a series of works by one patient, and soon becomes bored on seeing psychotic creations, once the first moment of surprise has passed. The arid, stereotyped and fixed elements in the content and particularly in the shapes show the mental stagnation.**[24]

Although access to the unconscious is necessary for creative work, the ego must not be overwhelmed by the unconscious. Creativity requires judgment, persistence, and control, none of which can operate effectively in the psychotic.

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QUESTIONS BASED ON THIS LESSON

41. In Havelock Ellis' 1904 study of the biographies of creative genius, the author noted that:

A. 44% of the group manifested psychoses at some time in their lives

B. Only 4.2% were demonstrably insane

C. Mental illness was more likely to occur among the educated and successful

D. There was a high correlation between creative genius and general emotional instability

42. Studies of temperamental differences among creative individuals indicate that "convergers" differ from "divergers" in that "convergers":

A. Do well in open-ended testing

B. Express unconventional attitudes

C. Are more interested in people-oriented subjects than things

D. Do not easily recall dreams and are emotionally inhibited

43. Which of the following statements about creative personalities is correct?

A. Creative writers obtain superior scores on MMPI items predicting successful recovery from neurosis

B. Creative painters and architects show a marked aversion for the complex and asymmetrical

C. The highly creative individual is much more likely to belong to professional associations and numerous social groups than the less creative person

D. Skepticism, i.e. the freedom to question preexisting assumptions, tends to thwart creative thinking

over, please...

44. Which of the following statements about creative personalities is not correct?

A. They rank sense of humor as one of their most valuable assets

B. Although creative work requires intelligence, there is little correlation between creativity and the highest ranges of IQ

C. Creative male subjects seem to rate extremely low on the femininity scale of the MMPI

D. Distinguished writers score high on schizoid, depressive, hysterical and psychopathic scales of the MMPI

Directions in
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VOLUME 1 • LESSON 12

Diagnosis and Treatment of Passive-Aggressive Personality Disorder

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EDITOR'S NOTE

We are all surrounded by passive aggressive behavior (hopefully less than more). When such behavior becomes truly pronounced, it assumes the form of an official DSM-III-R diagnosis referred to as Passive Aggressive Personality Disorder, which may stand by itself or be coexistent with other diagnoses, most commonly affective disorders, substance abuse, adjustment disorders, obsessive-compulsive behavior, and narcissistic personality disorder.

The diagnosis of PAPD calls for at least five of the following behavioral patterns: procrastination; irritability when asked to do something one does not want to do; a deliberate slowness at work or doing a bad job, again when someone does not want to do something or as an expression of disturbed interpersonal relationships; protesting, without justification, that unreasonable demands have been placed on one; avoiding obligations by forgetting; exaggerating how good a job one is doing; resenting useful suggestions from others; obstructing the efforts of others by failing to carry one's share of responsibility; and unreasonably criticizing persons in positions of legitimate authority.

In this lesson the authors present extremely useful tactics that counselors can use in dealing with passive aggressive behavior. Paradoxical injunctions, for example, involve making predictions or prescribing behaviors in a direction opposite to the hoped-for outcome so that the client will further the treatment by attempting to defeat the counselor. Assertiveness training can be especially useful. Interpersonal approaches involve first engaging the client in a relationship similar to that which the client expects, then changing direction and pulling him into different and constructive behavior interactions.

Background

The passive aggressive personality disorder (PAPD) has had a long and varied history dating back at least to Hippocrates' "choleric temperament" and to Theophrastus' "grumbler." The psychoanalytic "oral character" captured many of the elements now included with PAPD and there have also been many other formulations of a similar cluster of characteristics identified within descriptive psychiatry and clinical psychology. It is perhaps unfortunate that the modern use (and misuse) of the PAPD diagnosis has been so much associated with the military's need to describe those individuals who rebel against discipline. In fact it was during World War II that PAPD was first defined formally as a psychiatric diagnosis within the military nomenclature and soon it became a leading cause of psychiatric inpatient admission and administrative discharge. Although PAPD was included in DSM-I and DSM-II, its inclusion into DSM-III was done somewhat begrudgingly and initially required that the PAPD diagnosis not be made if another personality disorder was also present. This unnecessarily restrictive stipulation has been dropped in DSM-III-R because of the realization that PAPD is commonly encountered in clinical practice, both psychiatric and medical, and is a frequent cause of morbidity and of treatment failure. We will discuss the methods of diagnosis and treatment for PAPD, and will present an illustrative case.

Diagnosis

The DSM-III-R criteria for PAPD are: A pervasive pattern of passive resistance to demands for adequate social and occupational performance, beginning by early adulthood and present in a variety

of contexts, as indicated by at least five of the following: (1) procrastinates, i.e., puts off things that need to be done so that deadlines are not met; (2) **becomes sulky, irritable, or argumentative when asked to do something he or she does not want to do; (3) seems to work deliberately slowly or to do a bad job on tasks that he or she really does not want to do; (4) protests, without justification, that others make unreasonable demands on him or her; (5) avoids obligations by claiming to have "forgotten;" (6) believes that he or she is doing a much better job than others think he or she is doing; (7) resents useful suggestions from others as to how he or she could be more productive; (8) obstructs the efforts of others by failing to do his or her share of the work; (9) unreasonably criticizes or scorns persons in positions of authority.**

Special Assessment Problems:

The PAPD diagnosis is particularly difficult to make based on one or even several interviews. Under certain conditions it is likely to be wildly overdiagnosed; under others it is very likely to be missed. **PAPD is overdiagnosed in restrictive settings** such as the military, prisons, or boarding schools, all of which tend to elicit passive aggressive behaviors as an adaptive response to an environment that tends to discourage other more open forms of assertion. For an individual to meet criteria for PAPD, his behaviors must be pervasively passive aggressive and occur in a wide variety of social and occupational situations, even those in which more direct and effective expressions of assertion are possible. **A passive aggressive response to a single circumscribed situation or stressor should be diagnosed**

(if a diagnosis is in order) as an adjustment disorder, not as a personality disorder. PAPD is probably overdiagnosed in adolescents and young adults for whom the behavior pattern may often represent a development reaction rather than a personality disorder.

PAPD is frequently underdiagnosed because many individuals who display the behaviors in question do so in a fashion that is very ego syntonic and outside their awareness. Such individuals are likely to blame others rather than themselves for the consequent troubles they experience and are therefore poor informants concerning the items that make up the DSM-III R criteria set. The diagnosis often requires especially careful systematic questioning, the use of other informants, and observations of the client's actual behavior in the treatment situation. At times, the PAPD diagnosis becomes established only after the client has been in treatment for some time.

Overlapping Diagnoses:

Clients who meet criteria for PAPD are likely also to meet criteria for a number of other diagnoses both on Axis I and Axis II. The most common concomitant Axis I disorders are the affective, anxiety, substance abuse, and adjustment disorders. The most common concomitant Axis II disorders are the dependent, avoidant, obsessive/compulsive, self-defeating, and narcissistic disorders. PAPD is a frequent problem in the treatment of psychiatric and medical disorders, particularly when compliance with a medication regimen is crucial. It must be realized that PAPD will only rarely occur as the only diagnosis given to a client and that the management of PAPD will vary considerably depending on the other conditions that are also present.

Treatment

The first and particularly crucial step in treating any client, but especially an individual meeting criteria for PAPD, is the establishment of **rapport and a good therapeutic relationship to serve as a foundation when things get difficult.** PAPD clients are almost by definition particularly hard to engage in a good treatment relationship and will require from the rehabilitation counselor a higher than usual level of **patience and empathy. The most common countertransference pitfalls are either to engage in needless power struggles (a trap for the domineering therapist) or, on the contrary, to avoid struggles even at the cost of becoming as passive as the client.** A variety of different techniques are usually necessary in the treatment of PAPD and are often particularly helpful in combination.

Paradoxical Injunction:

This is a form of therapeutic "jiujitsu" which is particularly useful with PAPD clients because it **capitalizes on their oppositionalism, rather than locking horns with it. The counselor makes predictions or prescribes behaviors in a direction opposite to the hoped-for outcome so that the client will paradoxically further the treatment by defeating the counselor** (common examples include predicting that treatment won't work or that the client will be consistently late, or suggesting that the client probably has a good reason for not doing work assignments on time and should not change this precipitously, or recommending that the client not take the indicated medicine before doing very thorough research on its side effects and complications, etc.). PAPD clients are particularly prone to fight against direct advice and so often must be guided by indirection.

Psychoeducation:

PAPD clients are likely to be very unaware of the impact they have on others and why people become so frustrated with them. They are usually much more aware of their passivity than of the inflexible oppositionalism that often accompanies it. In order for the client to become motivated to change, there first must be **a comprehensive and systematic psychoeducation about these behaviors in order that they become more ego dystonic and available for remediation.** Having clients read the PAPD section of DSM-III is often very useful in this regard and may elicit a knowing smile.

Psychodynamic Techniques:

Most PAPD clients have conscious and unconscious conflicts over attachment/autonomy. They feel and behave as if their personal integrity is threatened even by casual submission to reasonable demands (e.g., being on time), but are also **frightened that any open expression of assertiveness will be damaging to others or will be met by damaging retaliation. Such fears have often arisen in a family context that discouraged open and adaptive assertion and encouraged the quiet expression of power struggles.** The psychodynamic approach to PAPD is to **confront the client's distortions as these become manifest in the transference** and to **interpret the unconscious wishes and fears expressed through the passive aggressive defenses as these emerge in the client's outside life, the transference, dreams, and fantasies.** Such intrapsychic and interpersonal conflicts are then traced back to early interpersonal relationships in order to assist the client to gain greater control and distance from them.

Behavioral Techniques:

Assertiveness training is useful to allow the PAPD client to express wishes openly and adaptively rather than in a covert and resistant fashion, and to expose the client to the anxiety experienced as a result of assertive behavior. The counselor can also assign **behavioral homework** to encourage the client to tolerate exposure to the anxiety of obeying others in situations in which this is appropriate (being on time, completing assignments as suggested, etc.). The client is taught to gain control of assertive and submitting behaviors rather than displaying a reflex tendency toward passive-aggressive avoidance. **Behavioral and psychodynamic techniques are particularly effective when used in conjunction with one another**.

Cognitive Approach:

Most PAPD clients have automatic cognitions that they cannot and will not get their way no matter how hard they try, that they are not worth very much, that other people are making unreasonable demands upon them, but that they are trying as hard as they can, and that the world is unfair and frustrating. The cognitive therapy approach focuses the client's attention on these cognitions as they arise in the sessions and also during the course of the week. The client is instructed to **keep a diary noting in systematic fashion the automatic, self-defeating cognitions associated with PAPD, the contexts in which**

they arise, their consequences, and the contrasting realistic appraisal of the situation. Cognitive reframing is also often useful. A client learns to understand his struggle differently when he comes to realize that an assignment submitted late may be worthless no matter how perfectly it has been done, that the boss also has his boss and his responsibilities, and that a given task has probably been assigned for reasons other than to make the client's life difficult, etc.

Interpersonal Circumplex:

The interpersonal circumplex is a sophisticated and fascinating method of measuring and mapping interpersonal behaviors and making predictions about how individuals are likely to interact with one another. Passive oppositionalism has been detected consistently as a characteristic pattern of behavior in empirical studies using the circumplex model and certain predictions have been made about the interpersonal behavior of such individuals and the likely response they will get from those with whom they interact. **Since submissiveness tends to "pull" dominance from others, and hostility tends to "pull" hostility, the prediction based on circumplex theory is that PAPD individuals will tend to bring out the hostile dominance in others**--e.g., bosses, spouses, and counselors. **This leads to positive feedback loops and self-fulfilling prophesies in which the client and his partners fulfill each others' expectations and bring out the worst in one another.** The interpersonal circumplex model also makes a prediction concerning therapeutic change. **In order for the counselor to be effective, he will first have to engage the client in a relationship of the kind the client expects, but then change direction and**

gradually "pull" for different behaviors from the client. The counselor can achieve this by avoiding the tendency to act in a dominant and hostile fashion.

Format of Treatment:

Although individual therapy is useful for many PAPD individuals, it has the disadvantage that the counselor is likely to quickly become engaged in power struggles with the client at the expense of the therapeutic alliance and therapeutic neutrality. **Family and group treatments are therefore often desirable as the treatment of choice or as an adjunct to individual treatment.** In the family or group format, the client is more likely to engage in power struggles with someone other than the counselor which makes it easier for the counselor to point out what is going on.

Duration of Treatment:

Some PAPD clients catch on very quickly to their repetitive patterns, make decisive changes in their behavior, and do quite well in short-term treatments of 6-30 sessions. Other PAPD clients show the same remarkable stubbornness to change in treatment as they display in life and may require long treatments and great patience from the counselor. For all of the longer treatments, and for those shorter treatments which get stalemated, consultations with another counselor are often useful to keep things moving and to regain therapeutic neutrality and a more productive therapeutic relationship.

Case Example--Ms. PA

History:

Ms. PA is a 28-year-old administrative assistant who presents for rehabilitative counseling because she is unhappy and feels her life is going nowhere. Although she is well-educated, intelligent, and attractive, Ms. PA is stalled both professionally and in her relationships with men. She has had six jobs since graduation from college, none lasting more than one year. In each instance, she feels that excessive demands were made upon her and that co-workers received preferential treatment. Her bosses have generally expressed admiration for her ability, and affection for her personally, but they also come to feel considerable exasperation because of her unwillingness to be a "team player." They claim that Ms. PA is hard to train, misses deadlines, disregards orders, and is generally more trouble than she is worth. (On several occasions she has been told the equivalent of "in your own quiet way, you are impossible to put up with.") In contrast, Ms. PA sees herself as a hard worker who gets into trouble merely because she refuses to "brown nose" or "play office politics." On close questioning, however, she does acknowledge being consistently late for work and doing her assignments in her own way and at her own pace, but she believes that allowances should be made because her work, when finally completed, is carefully done and well above average.

Ms. PA's problems with boyfriends parallel those she has had at work. She has no trouble meeting men or in interesting them in taking her out. Difficulties generally develop only after they get close enough so that decisions must be arrived at jointly. At first Ms. PA seems charming and amusing, but boyfriends wind up complaining that (again, in "her own quiet way") she is dawdling, stubborn, oppositional, always has to have things done her way, digs in her heels over trivialities, and is never on time. Boyfriends part with Ms. PA only with considerable reluctance. Again, they say that they really like her a lot, but have come to believe that its not worth the trouble. Ms. PA is aware she decidedly has "a mind of her own" but has little insight into the degree to which her understated, but nonetheless distinct, inflexibility has impaired her professional and personal relationships.

Ms. PA is the eldest of five children of a well-organized, perhaps even overly regimented, upper middle-class family. **Both parents are psychotherapists and, in their own quiet way, they were both fanatical about achieving schedules and levels of performance from their children. They were therefore thoroughly frustrated with Ms. PA's consistent lateness and also with her underachievement in school, sports, and social life.** They tried to order her, reason with her, bully her, and even developed systematic reinforcement contingencies--all to no avail. They succeeded in forcing her into tutoring programs, music school, dance lessons, and sports camps but she was always late for activities, uninterested, unwilling to practice, and generally so resistant that her tutors or counselors advised her parents to allow her to drop out. They were told "you can bring a horse to water but you can't force it to drink." Ms. PA was brought to several different counselors but had little or nothing to say to any of them. In her history she revealed little or no inclination to play with other's as a child; her teachers were generally frustrated by her failure to come to class on time or complete her homework but they also noted her superior potential and found her a quiet and likeable child nonetheless.

Ms. PA took six years to complete college mostly because she had many incompletes and found it especially difficult to get papers written on time. The thing that frustrates her the most now is that even when she sets up her own schedules, which she has begun to do, she is just as unable to follow them as those schedules established for her by others.

Diagnosis:

Ms. PA meets most of the criteria for passive aggressive personality disorder as these are listed in DSM-III-R. She has **a pervasive tendency (in work and social relationships) to resist demands for adequate performance** and this is **generally done indirectly rather than by asserting herself** in a more adaptive fashion. **She procrastinates, forgets, and is inefficient, argumentative, and stubborn. She overestimates the quality of her work and resents even well meant advice and suggestions from others. She is constantly involved in unnecessary and unproductive power struggles. This behavior is of long standing and she brings the problem to each new situation.** Although Ms. PA experiences some mild symptoms of anxiety and depression, none of these are of sufficient severity to warrant an Axis I diagnosis. She has obsessive/compulsive personality features but these are not sufficient to meet criteria for another DSM-III disorder.

Treatment:

The counselor and Ms. PA hit it off well at first. **He took advantage of the good start to make a prediction--one that annoyed** her–that the treatment had little chance of working and that it probably would not last more than a few sessions. When she asked why he was so pessimistic, the counselor cited the fact that anyone's past performance is the best predictor of future treatment behavior and benefit. He pointed out that her consistent pattern was to start well, but quickly run into difficulties of a very particular and predictable type. As the counselor expected, the client took the prediction as a challenge and said she thought she was different now and did want treatment to work. The prediction thus served several purposes: to provide a foundation for additional similar interpretations that will become necessary when things do eventually turn sour, as a form of psychoeducation to render her behaviors increasingly ego dystonic, and probably most important, as a paradoxical injunction. Given the counselor's prediction of treatment difficulty, this young woman can defeat him only by making the treatment succeed. In contrast, therapeutic optimism is likely to bring out oppositional treatment defeatism in PAPD clients.

The next phase of the treatment took many months and consisted of a careful and systematic inquiry into the many ways in which the client's behaviors resulted in problems both at work and with boyfriends, and how these were now having a similar impact in the treatment. In order for the PAPD client to achieve the motivation to change behaviors which come very naturally, she must first become aware of them, of their consequences, and of other people's reactions. The client had often been told before that this or that behavior was annoying but had always managed to attribute the observations to the self-interest or misunderstanding of the other person and to emphasize her seeming cooperativeness with others. **The counselor managed to carve out a fairly neutral position which allowed him to point out to the client the unwitting self-defeating attitude of consistently being late for sessions as well as for her job, of "forgetting" to do agreed upon homework assignments, and of her always saying "yes, but" to his interpretations and suggestions.**

The counseling of Ms. PA was conducted over a period of two years, once a week, and made use of a combination of a number of different, but complementary, techniques derived from the psychodynamic, behavioral, cognitive, paradoxical, and interpersonal orientations. **The counselor suggested specific behavioral exercises** (making an effort to arrive on time or even early, beginning work assignments early and doing a predetermined amount of work each day, allowing a boyfriend to choose the movie without holding a grudge). These assignments served several purposes: most directly, to teach her these new behaviors, to **expose her to the anxiety that would arise when she submitted to a schedule,** and to **increase the affect generated by her unconscious conflicts regarding autonomy and submission** so that these could be interpreted psychodynamically with greater immediacy. Whenever the client complained, as she often did, that the counselor was a regimented tyrant who reminded her of her parents, he would attempt to disentangle the realistic vs. the transference aspects of this observation and trace how she tended to introduced authority conflicts with her parents into each new situation and relationship. With a therapeutic alliance strong enough to tolerate the heat generated by this transference relationship, **the client was able to discover that she relied on her reflex lateness and oppositionalism to**

protect her individuality and independence. *She had failed to learn* more direct and adaptive ways of asserting herself because she felt outgunned by her parents and was now unconsciously afraid that a boss or a boyfriend or counselor could, in a similar way, dominate and demean her. This situation also provoked unconscious sadomasochistic sexual fantasies which were largely unconscious; these were likely to be triggered especially in relationships with men and were defended against by her being a good girl, one who would never give in even if this giving in were symbolized in her by behavior as straightforward as being on time for a date.

In conjunction with the behavioral and psychodynamic techniques described above, the client also participated in **assertiveness training** on the presumption that her displaced and maladaptive oppositionalism would be less necessary if she were more confident in her ability to directly get what she wanted in an adaptive way. Behavioral exercises alternating compliance and assertion were systematically assigned throughout the treatment in order to provide the client with a greater sense of control over her submitting, asserting, and rebelling reactions in interpersonal relationships, particularly with people she regarded as authority figures. The implications of her automatic cognitions that submission means weakness and that assertion will be overwhelmed were explored, particularly as these appeared in relation to the behavioral exercises and to her thoughts about demands made at work.

Paradoxical injunctions became less necessary as the client became less oppositional within the treatment and also outside of it. At the outset of the treatment, however,these were often useful in shaping her behavior to improve the therapeutic alliance. For instance, probably the most effective way of dealing with her frequent lateness was for the counselor to insist on reducing session durations from 45 to 30 minutes. He stated that given her consistent 15 minutes of lateness, this was all the time that was left anyway. The client argued that she would still be 15 minutes late to the reduced session and that this would leave only 15 minutes–which was really not long enough for a productive session. The counselor said if the client were 15 minutes late for 30-minute sessions he would have to take the step of reducing the session duration once again, and so on with the obvious consequences Ms. PA began coming on time for the 30-minute sessions and soon asked that the sessions be returned to 45-minute duration. When this was done, she continued to come on time.

Perhaps the most important facilitator of change, and certainly a necessary one, was the nature of the interpersonal relationship that developed between the counselor and client. PAPD individuals exhibit a kind of hostile submission in interpersonal relationships that tends to elicit hostile domination from others around them partly because they feel forced to provide the client with direction and yet are constantly frustrated in these efforts. The counselor's behavior early in the treatment also had elements of domination but this was delivered, by and large, in a good natured and loving way which according to interpersonal theory is likely to elicit a more good natured and loving submissiveness from the client. As the treatment progressed the counselor attempted to manifest less and less direction and domination, which change in behavior, in a complementary fashion, "pulled" for less submissive behavior from

the client. Thus the counselor and client became increasingly less mutually hostile and more equal as the treatment progressed to successful termination. Ms. PA also became more assertive and less inflexibly resistant in her work and personal affairs, was soon promoted to a responsible job and became engaged.

Conclusion

There has been little systematic research on the diagnosis of PAPD and no research comparing various treatment approaches. it is clear, however, that this is a commonly encountered behavior pattern in clinical practice and one that occasions more than its share of problematic therapeutic relationships and failed treatments. We have discussed a number of approaches to the diagnosis and treatment of PAPD that can help the counselor to avoid the pitfalls and stalemates frequently encountered in work with such clients. Perhaps most important, however, is the clinician's attitude in working with oppositional clients. The counselor who will do best is one who can flexibly mix it up when this is the only way the PAPD client can enter into a relationship, but who can also forego a needless fight, and does not always have to be right or listened to.

STUDY GUIDE

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QUESTIONS BASED ON THIS LESSON

45. Making a diagnosis of Passive Aggressive Personality Disorder:

A. Is often made too readily in adolescents and young adults who are actually involved in developmental reactions rather than personality disorders

B. Requires the complete exclusion of any other DSM-III-R diagnosis

C. Precludes the concomitant diagnosis of affective disorder

D. Is only important to deal with compliance problems encountered in administering medication regimens

46. In the treatment of Passive Aggressive Personality Disorder:

A. A good therapeutic relationship with rapport is impossible to establish

B. It is best to avoid all power struggles, even at the risk of becoming extremely passive in one's therapeutic stance

C. The counselor must exert a powerful, authoritarian stance to get good results

D. Patience, empathy, and flexibility are key therapeutic attitudes

47. The tactic of paradoxical injunction involves:

A. Adamant insistence that the passive aggressive client forfeit his self-defeating and annoying behavior patterns

B. The counselor making predictions or prescribing behaviors in a direction opposite to the hoped for outcome so that the client will further the treatment by attempting to defeat the counselor

C. Enabling the client to gain direct insight into the impact of his or her behavior on others

D. Helping the client recognize and cope more directly with previously unconscious aggressive and assertive urges

over, please...

48. The interpersonal approach to the treatment of the Passive Aggressive Personality Disorder:

A. Requires that the counselor first engage the client in a relationship of the kind the client expects, and then change direction to "pull" different behaviors from him or her

B. Often includes family or group therapy as a valuable adjunct to individual therapy

C. Goes after the client's tendency to bring out the worst in him- or herself and in others

D. All of the above

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